

**IN THE MIDDLE: EXPERIENCING MEDICAID
AS A TEXAS HEALTHCARE PROVIDER**

A Dissertation

by

CADE WESLEY SPAULDING

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2011

Major Subject: Communication

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ABSTRACT

In the Middle: Experiencing Medicaid as a

Texas Healthcare Provider. (May 2011)

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In this study I investigate how healthcare workers, involved in the Texas Medicaid program as healthcare providers, cope with four workplace constraints. Healthcare workers are constrained by: 1) the policies and practices of the Medicaid program, 2) their own individual and professional values towards indigent care, 3) the rules and policies of their own organization and business type, and 4) the Medicaid patients with whom they interact. I use structuration theory and sensemaking to better understand how these professionals cope with these challenging constraints. Using in depth interviews of 36 private and public healthcare professionals from four unique fields of service (i.e., dental, optical, pediatric, mental health) I applied a modified grounded theory approach to understand: 1) how professionals make sense of the four Medicaid constraints described above, 2) how sensemaking strategies help or hinder professional performance, and 3) how sensemaking communication shapes professional identity and work perceptions.

Healthcare workers viewed Medicaid support staff as “flippant”, “rude”, incompetent, unhelpful, and unreliable. However, providers believed Medicaid was

equal to or better than other insurance companies for speed and reliability of payment. While they unanimously identified with providing indigent healthcare, they also clashed with the Medicaid program as a vehicle for those services. Private practices framed Medicaid as a liability while public non-profit organizations relied on Medicaid as a primary source of revenue. Providers agreed that Medicaid patients had poor follow-through, a high no-show rate, were undisciplined, and crowded provider offices with unscheduled family members. Healthcare workers enacted self-reliance as individuals, by networking with other Medicaid providers, and by relying on in-house experts. They also engaged in discursive strategies by minimizing, blaming, and detaching. They viewed themselves as disciplinarians, problem-solvers, advocates, and benefactors.

Theoretically, this study develops the concept of identity regions and reframes workplace constraints as necessary identity structures. It also suggests that how Medicaid patients behave may have a more damaging impact on whether providers are willing to work with Medicaid than low reimbursement rates.

DEDICATION

to my wife, eternal companion, and best friend whose daily example of love, sincerity,
sacrifice, work, determination, and patience motivate & shape all I aspire to be

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CHAPTER I

INTRODUCTION

The *Gallup Daily News* reported that one in six Americans were without health insurance as of July, 2010 (Mendez, 2010a). Recognizing the number of people in need of health coverage, the recently passed federal healthcare reform bill will require state Medicaid programs to cover “an additional 15 million people” over the next four years (Mendez, 2010a). Expansion of Medicaid eligibility means increased costs to state budgets and often translates into increased pressure on Medicaid healthcare providers who must deliver services to larger groups of people while they simultaneously experience financial losses from the lower Medicaid reimbursements.

Naturally, this strain will be most severe within those states that have the highest number of uninsured residents. With nearly 27% of its residents still uninsured (an increase of over 2% since 2005), Texas continues to have the highest number of uninsured residents of all the states in the country and stands to experience the most strain in response to this expansion of Medicaid coverage (Code Red, 2005, Mendez, 2010b). A recent article in the *Dallas Morning News* estimated that by 2015 the current federal healthcare reform could add 1.5 million Texans “by conservative estimates” to the state Medicaid program (Garrett, 2010). With these kinds of increases, it’s not hard to see how state Medicaid expenditures could consume nearly 50% of the entire state budget within the next 20 years (Code Red, 2005). Such budgetary demands will be felt

by residents through increased taxes and by organizations that depend on state funding as they experience spending cuts. However, Texas Medicaid providers often face the greatest challenges in providing care to Medicaid patients as a direct result of the financial strains the state is experiencing. They are “in the middle” – being asked to increase performance for less money while still facing the challenging obstacles that come from working with the Medicaid system.

Texas Medicaid providers are already facing many of these challenges. For example, the state legislature recently announced a 10% budget cut to all mental health funding within the state of Texas (Kelly, 2010). In the absence of this much needed state funding, mental health service providers could rely even more on Medicaid for financial reimbursement in spite of the lower reimbursement rates for those services. However, a 1.2 million dollar cut in Texas spending, announced in May of 2010, is set to reduce Medicaid reimbursement rates for doctors across the board (Frikac, 2010). This cut could hurt healthcare providers who rely on Medicaid as their primary source of income while discouraging other healthcare professionals from working with Medicaid at all. In fact, already some doctors “in the Dallas area and across Texas are threatening to opt out of Medicaid...which would further damage the state's already uneven delivery of health care to the poor” (Garrett, 2010).

Unfortunately, the number of health service providers (HSPs) willing to accept new Medicaid patients has been decreasing each year. One study found that “the percentage of physicians not accepting new Medicaid patients has risen from about 19.5 in the mid-1990s to about 21 percent over the past few years” (Freking, 2006, p. 1).

More recently, according to the Texas Health and Human Services Commission, less than one-third of the states' doctors currently accept Medicaid (NBCDFW.com, 2010). In addition, the Texas Medical Association reported in a recent survey that 45% of its members "said they would limit how many Medicaid patients they would treat if the Medicaid fees were cut by 1 or 2 percent, while another 24% said they would stop accepting any Medicaid patients" (NBCDFW.com, 2010). With the 1% reduction in reimbursement coming into effect as early as September 1, 2010, this could mean a substantial decline in the number of healthcare practices willing to serve Medicaid patients. Fewer and fewer HSPs are willing to sacrifice the time and the money required to navigate the uncertain waters of the Medicaid program. HSPs who do serve Medicaid patients are severely underpaid for their services and frustrated with aspects of the confusing, contradictory, and abusive bureaucracy (Engel, 2006; Freking, 2006; *Salt Lake Tribune*, 2007).

Healthcare service providers who continue serving Medicaid patients often experience extreme financial and caseload burdens. One mental health caseworker at a Texas MHMR (Mental Health & Mental Retardation) clinic mentioned to me in passing that she typically worked from 8am to 10pm at the office, received little pay, and had responsibilities for all the patients and potential future patients living in Brazos County and two adjacent counties. Working late hours was the only way she could complete the necessary work. Furthermore, patients who had qualified five years earlier for \$200.00/month in Medicaid funding now qualified for \$6.00 /every other month (Krejci, 2008; Texas Medicaid and Healthcare Partnership, 2004). Such dramatic changes to the

payment program at once increased the workload for staff while slashing their take-home pay and available financial resources to pay for treatment programs. Taking these conditions into perspective provides answers to a news article entitled “Where are the doctors who accept Medicaid?” (Salt Lake Tribune, 2007). With high costs and low returns, many of the doctors have gone elsewhere. Unfortunately, there are unexpected consequences for the Medicaid program in losing healthcare providers. While providers that leave may free themselves of the bureaucracy and poor payment for services, leaving the program concentrates the service demands of an entire population upon the shoulders of those who decide to stick it out. This creates a tremendous imbalance of services within the community, amplifying the constraints and pressures felt by healthcare workers within the Medicaid program. It is critical to understand how these workers manage their daily work within this demanding system. Such a study will also address the larger theoretical issues of how individuals within institutional systems manage the varying constraints of institutional norms and practices, organizational form and standards, personal values, and client needs and the extent to which they can and do use their agency to address problems in the system.

It’s clear that Medicaid healthcare provider personnel face unique challenges directly connected to their work with Medicaid. In order to more clearly understand the challenges they face, I need to clarify four primary constraints they must deal with through their work within the Medicaid system. After introducing these constraints, I will then discuss Giddens’ (1984) structuration theory and how it can help us better understand how these constraints challenge and enable healthcare workers to do their

daily work. Lastly, I will introduce Karl Weick's (1995) conceptualization of sensemaking as a way of getting at how workers generate meaning from the daily workplace tensions they experience with Medicaid in order to fashion the social rules and resources necessary to structure professional identity and perceptions of work.

Healthcare Providers Constrained

Healthcare service workers face four challenging constraints in the work they do. First, workers are constrained by the policies and protocols of the Medicaid program itself. Second, they are constrained by the personal and professional values they hold regarding indigent care. Third, they are constrained by the particular rules and policies related to Medicaid which are based on their organization's business type (i.e., private practice or public non-profit clinic) and the type of healthcare service they offer (e.g., dentistry, optometry, mental health, pediatrics, etc.) Fourth, they are constrained by the pressures that come from working with Medicaid patients themselves. These four constraints are not exhaustive, but represent the primary challenges workers face as they provide healthcare within the Medicaid system.

Constrained by Medicaid Policies and Protocols

One of the more obvious constraints Medicaid providers face deals with the policies and protocols of the program itself. Medicaid is a complex program with administration staff working at both the federal and state levels of government (Centers for Medicaid and Medicare, 2008) but the program depends entirely on local healthcare providers to deliver services to beneficiaries. According to the *Texas Medicaid Provider Procedures Manual* (Texas Medicaid and Healthcare Partnership, 2008):

The administration of the program is accomplished through contracts and agreements with medical providers; Texas Medicaid & Healthcare Partnership (TMHP), the claims administrator; MAXIMUS, the enrollment broker; various managed care organizations (MCOs); the Institute for Child Health Policy (ICHP), the quality monitor; and state agencies. Texas Medicaid providers are reimbursed for services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments.

Not only does this spell out the wide range of relationships necessary to maintain the Medicaid program, but it hints at the complex system within which these relationships are formed and maintained and through which information is processed and shared. The system of contracted relationships that constitutes the Medicaid program is at once complex, robust, and dynamic. As if to accentuate the complexity of the program, the Texas Medicaid Provider Procedures Manual is over 1100 pages long. This is quite a read for providers who consider working with Medicaid. To complicate things further, the relationships between healthcare providers and the Medicaid program are not without historic tensions.

Medicaid has had a thorny relationship with healthcare providers for many years. According to Engel (2006), even in its infancy, the Medicaid program had little support from the medical community. It wasn't long before professional organizations representing healthcare providers (e.g., American Medical Association, American Physicians Association) had justification for their distrust. Medicaid not only paid less

than many other insurance providers, but often reneged on payment altogether. Policies that ensured that Medicaid paid the absolute lowest cost for services – determined by the lowest price a doctor had offered to *any* patient for the same services, regardless of reason – have blackened the relationship between Medicaid and healthcare providers. With cumbersome bureaucratic rules, the complex program placed enormous stress on local practices. Medicaid became famous for mismanaging paperwork and denying or losing many of the medical claims it received. Ongoing bureaucratic mazes increased frustration and local doctors and national professional associations saw Medicaid as an institution whose costs far outweighed its returns. As a result, while there were many philanthropic groups still willing to face these challenges for the sake of needy patients, even in the early years a great many health providers simply refused to take part in the Medicaid program (Engel, 2006).

Conflicts between the medical community and the Medicaid program continue today with little change outside the natural exacerbation of the original problems (Engel, 2006). Dramatic financial discrepancies between what Medicaid pays and what other public and private programs pay remain a significant constraint for healthcare providers who continue to serve Medicaid patients. A study conducted by the Center for Studying Health System Change found that “Medicaid’s reimbursement policies are the biggest reason that it is getting more difficult to locate doctors who take new patients under the program” (Freking, 2006, p. 1). One report found that Medicaid pays roughly 80% of what Medicare typically pays for the same services and about 50% of what private insurance groups pay (Biles, 2007).

Even if healthcare providers are willing to take whatever Medicaid is willing to give, the process of getting paid can often be extremely aggravating. Freking (2006) notes that healthcare providers “frequently complain about the administrative hassles...[and] physicians often have to get approval [from Medicaid administrators] before prescribing medicine or conducting tests” (p. 1). Such policies bind healthcare providers with constant oversight, making even the most routine tasks both cumbersome and aggravating. Kansas State Senator Roger Reitz (also a physician) reports that “an increasing number of doctors are becoming ‘disenchanted’ with the paperwork and other bureaucracy tied to the assistance program” (Biles, 2007, p. 1).

In addition, even when providers jump through all the bureaucratic hoops in order to satisfy the rules and policies of the Medicaid program, they often run into problems with processing legitimate medical claims. Just as the decisions made over whether a family gets to be enrolled in Medicaid often “strike many parents as arbitrary” (Bernstein, 1998, p. 1), healthcare service providers are often confused about why their medical claims have been rejected. According to one report, “Texas physicians resubmitted denied claims at least twice over 47 percent of the time” (Ault, 2007) in order to get paid for their services and Texas-Medicaid ranked the lowest out of 14 payment programs (both public and private) in the western region with a 22.5% denial rate (Athenahealth, 2006). Such a high denial rate points to larger procedural concerns within the Medicaid program. It also hints at the enormous amount of time frontline staff must surrender in order to complete routine tasks as submitting and following up on Medicaid claims.

Constrained by Values toward Indigent Care

Not only do the rules and policies of Medicaid place a great deal of pressure and constraint upon healthcare workers through the numerous rules, policies, and procedures they invoke, but workers are also constrained by the professional and individual values they hold toward indigent care. Such values can stem from a variety of sources including perceptions of the welfare system, professional and personal commitments to healthcare, and personal experiences.

Research on organizational identification can help explain the impact of professional and personal values on individual actions. Tompkins and Cheney (1985) argue that as individuals more closely identify with organizationally approved values, these values begin to influence their decisions. These scholars also argue that such workers will only “see” alternatives that agree with the values of the organization. In this way, individual decisions are influenced by close identification with organizational values in two ways. First, identification influences the potential alternatives a person will consider. Second, close identification will ultimately influence what choice an individual makes (i.e., one that would be in the best interest of the organization).

Research on organizational identification has emphasized the role that multiple targets of identification have on individual choices (Larson & Pepper, 2003; Pepper & Larson, 2006; Scott, Corman, & Cheney, 1998). Not only are professional healthcare workers, for example, influenced by the organization for which they are employed, but also by professional memberships, community memberships, and personal relationships outside their workplace.

It makes sense that professionals are often influenced by what they hear from others about the Medicaid program, and the relationship between Medicaid and healthcare workers is sketchy at best. Both informal relationships and formal membership with outside groups pressure healthcare workers in conflicting ways. First, there is a long history of antagonism between state-funded healthcare programs and healthcare providers that has created a generally pessimistic view of Medicaid and the patients who rely on it (Engel, 2006). This animosity comes at least in part from the very real problems private practices face in getting paid for healthcare services. Further, professional associations have long had a mixed record of support for government programs like Medicaid. Among those who have expressed political antagonism to Medicaid are the American Physician's Association, the American Psychiatric Association, and the American Medical Association (Engel, 2006). Healthcare professionals who pay for membership in a national professional association stand to be influenced, at least to some degree, by the espoused values of these groups.

However, the number of HSPs still willing to care for Medicaid patients suggests a different set of professional values that are also at work within the industry. With financial losses, increased patient case loads, and ongoing pressure from outside national organizations against Medicaid, it would make sense that some healthcare workers have strong reasons for not participating in the program. Thus, it's difficult not to conclude that the only motivating factors for taking on Medicaid patients are philanthropy and altruism. Doctors, nurses, and other medical staff have a long history of donating time and money through professional services to the poor and needy (Engel, 2006); in spite of

the clearly negative view of the Medicaid program, many members of the medical community are undoubtedly influenced by these fundamental values regarding care for others.

Scott, et al. (1998) have taken a structurational view of identification that provides some insight into how these professional and personal values influence daily work decisions. They argue that structures of values constitute identities and that these structures often support and/or compete with one another to varying degrees. Scott, et al. suggest that employees who closely identify with their work draw upon the rules and resources connected to their jobs and their immediate work environment as a way of making sense of their own professional identities. Further, communication about those structures of values, beliefs, and norms serves to engender even closer identification with professional values and more localized work cultures. Healthcare workers may be constrained by the beliefs and value structures of their profession and work environment, but through communication they also influence, reinterpret, and prioritize the values that make up their professional identity.

Constrained by Organization and Healthcare Service Type

Organization and healthcare service type also contribute to how workers are able to deal with the pressures they encounter. Organization type describes how HSPs vary according to whether they are private practices or public non-profit entities. Private practices are more vulnerable to market changes and must compete with one another for business. This means that patients have more choices and that both professional and frontline staff are expected to measure up to patient expectations. As mentioned

previously, many of the private sector doctors and HSPs have felt compelled to reduce and/or completely cut off services to Medicaid patients because they are not able to cover their overhead costs with the reimbursements Medicaid provides (Biles, 2007; Freking, 2006; NBCDFW.com, 2010). In addition, service providers within the Medicaid program are often overwhelmed with patients simply because there are not enough providers to serve the entire population that needs services. This makes it more difficult to compete with similar organizations that have the funding to hire additional frontline staff, more up-to-date equipment, and/or additional professionals to cope with increased patient caseloads. In contrast, public non-profit employees face increased spending cuts to essential patient services based on legislative spending decisions rather than private market considerations. Because their services are often geared toward indigent populations, individual organizations do not need to compete for patient caseloads. Within a public sector HSP, it would make sense that financial cuts would decrease working staff and increase patient caseloads, placing considerable pressure on both frontline and professional staff.

While organization type has considerable influence on the kind of challenges and pressures HSP organizations face, the healthcare service each organization provides (e.g., dentistry, optometry, pediatrics, general medicine, OBGYN, surgery) also plays an important role in shaping the challenges workers face. For example, factors such as duration of care and frequency of interaction play out differently in dental and optometry practices than in HSPs that offer care in pediatrics, general medicine, mental health, and OBGYN. While the former business types service people roughly once a year for

routine checkups and services, the latter typically care for patients (especially children, elderly, and the disabled) far more frequently. Similarly, because the managed care system requires a formal referral from a child's pediatrician for any outside care (Texas Medicaid and Healthcare Partnership, 2008), pediatricians play a far more central role in a child's healthcare than other HSPs. Further, while many general medicine and pediatric practices have adopted the managed care system by using frontline staff as the "face" of the organization (Miller, 2001), psychologists and psychiatrists usually interact directly with their patients on a more frequent basis.

Constrained by Pressures of Medicaid Patients

Patients themselves impose several constraints on healthcare workers. As the number of doctors willing to accept Medicaid patients dwindles, patients needing care are restricted to the healthcare providers who will treat them. This places enormous pressure on healthcare workers by demanding more for less. It can also translate into financial and even ethical dilemmas as providers attempt to provide healthcare services to a growing population of individuals who have nowhere else to go. While providers may continue to accept Medicaid patients, they do so by accepting financial losses and potentially reducing their working staff, cutting back on overhead, increasing patient loads, or reducing pay.

One of the clearest examples of the pressures healthcare providers face comes from the frustration clients themselves feel with the program. Medicaid patients face many dilemmas that make it difficult for them to receive healthcare. The first, of course, is simply finding healthcare providers willing to provide treatment. Many patients also

face frustrations because of their financial situation. Sered and Fernandopulle (2004) chronicled the story of a woman who worked as an in-home nurse. Her daily work included physical demands that aggravated her arthritis, but she couldn't afford the cost of medicine without outside help. Because her pay exceeded the state entitlement standards she was unable to simultaneously qualify for Medicaid and keep her job, but she couldn't keep performing her job without the medications she needed to keep her arthritis under control. Ultimately, she quit her job in order to qualify for Medicaid and get the medications she needed.

Sadly, the policies and rules that govern Medicaid sometimes motivate people to stay on the program rather than get off the program (Sered & Fernandopulle, 2004). This places obvious pressure on clients of the Medicaid program, and inadvertently places pressure on service providers as well. Many times clients are unaware if they have been dropped from Medicaid services whether for legitimate reasons or by accident. In Texas, Medicaid applications have to be renewed with updated information for each person on the program every 6 months (Texas Medicaid and Healthcare Partnership, 2008). With this much paperwork moving through the system, it isn't surprising that some information might fall between the cracks and delay or prevent reapplication to the program. For example, my family was dropped unexpectedly and without warning from Medicaid services for our children at least half a dozen times during our time in Texas. Many times it wasn't until we showed up at an appointment that front desk workers discovered our child's Medicaid card was no longer active. Most of the time, this happened as a result of clerical mistakes made by caseworkers or others

during reassessment and took weeks to resolve. The stress this places on those needing the medical services is understandable. However, this situation also places emotional and clerical pressures on frontline staff by placing them in an extremely uncomfortable position. After all, it is their job to deliver the “bad news” and inform the individual or parent that Medicaid coverage is no longer active.

Summary of Constraints

Healthcare workers face at least four major constraints that influence how they make sense of themselves as professionals and the work they do. They are constrained by the bureaucratic protocols and policies found in the Medicaid program itself and also on an individual level by the professional, organizational, and individual values they embrace. The type of business they operate and the kinds of healthcare services they offer can constrain how they are reimbursed, the rules they are required to follow, and what kinds of pressures they face from within their own communities. Healthcare workers also face constraints from the Medicaid patients they interact with during office visits.

Common to each of these constraints are the healthcare workers who are caught in the middle. It might be easy to describe these health care workers as simply caught between the proverbial “rock-and-a-hard-place.” However, the situation is more complicated than that, as many of these constraints reinforce one another and place combined pressure on healthcare workers at multiple points simultaneously. Challenges with inflexible and confusing policies, for example, can easily play into how Medicaid patients interact with frontline staff and the kinds of constraints a business might feel in

trying to satisfy frustrated patients. Similarly, when healthcare service providers are not able to continue serving some clients because they have been unexpectedly dropped from the Medicaid system, they may feel that their personal or professional values have been compromised. Daily work life involves engaging a complex social system of relationships and meaning. Such meanings are inherently communicative in nature. Nurses, frontline staff, doctors, dentists, assistants, and mental health caseworkers constantly make sense of who they are and what they are doing based on the ongoing relationships they have with Medicaid personnel, patients, and each other. These communicative interactions constitute the Medicaid system and form the foundation of Giddens' (1984) structuration theory.

Structuration Theory and Medicaid Constraints

Structuration theory (Giddens, 1984) is a useful theoretical lens to better understand the constraints that affect healthcare workers providing service within the Medicaid program. It is helpful because it recognizes the constraints HSPs face as challenging structures that influence their daily work lives without denying that they have the ability to reinterpret those constraints. After all, in spite of many challenges, many practices and clinics are still interested in being Medicaid providers. Somehow, these practices have found a way to negotiate the complex structures around them and provide care. Thus, it appears that workers exercise their agency and, to varying degrees, have the ability to shape their own work conditions. In this section, I will first provide a general overview of Giddens' theory of structuration and then apply the theory to each of the four constraints facing healthcare personnel.

Overview of Structuration Theory

Poole and McPhee (2005) observed that one of the great strengths of structuration theory is that it emphasizes the role of human communication as a critical process that links individual actions to larger social institutions and vice versa. They emphasize that structuration theory looks at organizations as systems of interacting “human practices” where practices are defined as “patterns of activity that are meaningful to those engaged in them” (Poole & McPhee, 2005, p. 174). I will discuss the following concepts related to structuration theory: agency, structure, duality of structure, material and structural constraints, and sanctions.

Agency and Structure

According to Giddens (1984), agency refers to the ability individuals have, at any point within a series of actions, to act in a way other than how they actually do act. In other words, agency exists when people have choice points and action alternatives. This does not imply, however, that agency is always conscious. Giddens is careful to make the distinction that “agency refers not to the *intentions* people have in doing things but to their *capability* of doing those things in the first place” (italics mine, p. 9). Emphasizing capability over intentionality affects how we view both agency and the human condition. A person can be capable of particular alternatives and unintentionally choose one alternative over another simply out of habit (e.g., when a person driving down the road slips into “auto pilot” and doesn’t realize they are off course until they have arrived at the unintended destination). Structuration theory addresses several assumptions about

human nature that shape the condition of agency and its expression through both intentional and unintentional choices.

Poole and McPhee (2005) argue that structuration theorists make at least three basic assumptions about human beings whenever they attempt to explain communicative agency. First, there is the assumption of at least three levels of consciousness: discursive, practical, and unconscious. Giddens (1984) frames *discursive consciousness* as that level of consciousness where people are able to communicate experiences and knowledge through words and symbolic action. Discursive consciousness is accessed when “we are aware of some rules and resources in such a way that we can express and explain them to others and use them to give an account of our actions” (p. 176). Practical consciousness is rooted in knowledge and experiences that are difficult and at times impossible to put into words. Riding a bicycle and being able to read a person’s personality are good examples of this level of awareness (Poole & McPhee). The final level of consciousness is the lack thereof – the unconscious. Giddens refers to the unconscious as our “ontological security” or the “confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity” (p. 375).

The second general assumption about human agents is that they are knowledgeable actors (Poole & McPhee, 2005). In other words, people act on knowledge they possess. This knowledge is rooted within the levels of consciousness just described and therefore can be at the highest level of consciousness and something they can talk with others about (i.e., how to submit a Medicaid claim), something that

can only be gained by engaging in particular practices (i.e., what it's "like" to talk with a less than knowledgeable Medicaid caseworker over the phone), or something that is actually barred from conscious thought (i.e., the experiences that have shaped a person's beliefs and worldview about poverty care).

Third, human agents are able to reflexively monitor their own actions and their own choices. As such, they are able to prioritize one action over another (Poole & McPhee, 2005). They are also able to make sense or give meaning and order to actions that would otherwise remain part of a never ending stream of events and experiences (Giddens, 1984). Without the capacity to reflect upon ourselves, agents would be hard pressed to make sense of themselves, let alone their place within an organization or profession. Giddens (1984) argues that social structures are made up of "rules and resources" that create "the 'binding' of time-space in social systems" (p. 17). Poole and McPhee (2005) define a rule as "any principle or routine that guides people's actions" (p. 174) and Giddens argues that rules provide direction to actors by creating meaning. Specifically, rules highlight particular meanings over others based on how they are communicated within society. However, because meanings are rarely fixed, singular, or beyond the influence of individual perception, actors often interpret equivocal meanings as they individually make sense of social rules in order to translate them into situational practices. The impact individual agents can have on how rules are interpreted reinforces the power of agents over the social rules around them. Giddens reinforces this image of agential advantage by recognizing that "*the discursive formulation of a rule is already an interpretation of it, and...may in and of itself alter the form of its application*" (1984,

p. 23). In other words, our interpretation of a rule via communication has the potential to alter how we put that rule into practice.

In addition to providing social guidance to actors via meanings, social rules also provide justification for action by “*sanctioning* [particular]...modes of social conduct” over other potential options (Giddens, 1984, p. 18). These modes of social conduct make up what Giddens (1984) calls social resources. Resources are the tools or “modes” actors draw upon as they use their agency to enact social rules. Poole and McPhee (2005) define a resource as “anything people are able to use in action, whether material (money, tools) or nonmaterial (knowledge, skill)” (p. 174). Thus, “resources are the media through which power is exercised” (Giddens, p. 16), meaning is expressed, and by which norms of practice are maintained. In short, rules give direction, meaning, and justification, while resources are the material and social assets actors draw upon to enact particular rules in practice.

Duality of Structure

At the heart of Giddens’ (1984) theory of structuration is the concept of duality of structure. Rooted in practices, the duality of structure refers to the interdependent and simultaneous influence of agency on social structure and social structure on agency found in every social interaction. Giddens argues that social structures are not separate from but are essentially maintained by the regulative practices of individual agents. Without the ongoing practices of individual agents, adhering to rules as both a way of understanding the world and as a means of justifying their own actions and then drawing upon material and symbolic resources in order to enact those rules, even the most

entrenched social structures would collapse. However, the duality of structure situates structure as both the product (e.g., current indigent healthcare programs like Medicaid) and the process that leads to that product (e.g., the routines and practices agents enact in order to legitimize and otherwise constitute a complex program like Medicaid). Giddens argues that agents ultimately control the process of structuring (through practices) which leads to the final product of social structure through their choices of how to enact and make sense of structural rules and resources. Recognizing that agency does not always mean intentionality, it makes sense that many of the entrenched social systems of our daily lives can become so normalized that they slip beyond our conscious recognition into unconscious routines.

Rules and resources provide both the raw material for maintaining social structures and the creative fodder necessary to transform them. For example, if I take a job that requires me to be to work at 6am, I may not be able to stay up late or sleep in when I'm tired. The structure of the new job prevents me from making some choices I might otherwise make. However, agents are capable of interpreting their own meanings which allows opportunities to reinterpret the nature of the rule by drawing on alternative social resources. Again, while I may need to begin work at 6am, it may be possible to redefine work from an activity that occurs in an office, to an activity that begins on my laptop at home and then moves to the office around 10am. Of course, structural features such as hierarchy may limit my ability to fully transform the nature of my work structure, but within certain constraints the possibility is there. It is this condition of being able to act otherwise that makes it possible to not only draw upon the rules and

resources of social structures as a means of maintaining social norms/institutions as they are, but also as a way to transform structures in creative ways. In other words, people make the difference. Having alternatives available is at the heart of being an agent, but making changes to social structure comes with both predictable and unexpected consequences. While I may receive permission to begin my work day at home, I may not anticipate the effect of this on my family. For example, it may become difficult for my children to distinguish when dad is home and when he is at work, creating more tension at home. On the up side, I may find that I get more work done because I am able to get more sleep without the travel time to the office. Ultimately, my agency may have the unexpected consequence of flooding my boss's office with appeals from other workers who want a more leisurely morning as well. Thus, using my agency to transform (and/or maintain) a particular social structure has consequences that can both limit and expand my future choices.

Material Constraints, Sanctions, and Structural Constraints

According to Giddens (1984) structures are different from constraints. Structures are the rules and resources that give agents the necessary guidance and materials to act on their own. Constraints are limitations that are placed on human agency. In other words, constraints limit the amount and kinds of rules and resources available to agents as they act. There are at least three kinds of constraints Giddens talks about: material constraints, sanctions, and structural constraints. He defines *material constraints* as the "limits which the physical capacities of the human body, plus relevant features of the physical environment, place upon the feasible options open to agents" (p. 174). A

healthcare worker, for example, is only able to work so many hours in a day before physical, mental, and emotional fatigue will begin to affect performance. *Sanctions* refer to power exerted by people upon other people. These constraints can range “from the direct application of force or violence, or the threat of such application, to the mild expression of disapproval.” (Giddens, 1984 p. 175). Sanctions are therefore deterrents and usually require the consent of the person being sanctioned before they can limit or control that person’s actions. Giddens argues that aside from the rare instance when physical force is used to render a person completely helpless “all other sanctions, no matter how oppressive and comprehensive they may be, demand some kind of acquiescence from those subject to them” (p. 175).

Lastly, there are *structural constraints* which use the threat of a sanction on something we hold dear to limit the potential actions agents are willing to perform. Structural constraints are rooted in the rules and resources needed to perform social action. While material constraints are physical, structural constraints are social. Giddens (1984) uses the example of the capitalistic labor market. A person contracts to work for an employer and by so doing agrees to perform certain tasks and conform to a particular work schedule in exchange for a pay check. The need to pay for food, clothes, etc. fuels the need to maintain this contractual relationship with the employer. Thus, in a labor market where workers are dependent upon employers to provide the means necessary for survival and employers are dependent upon employees for providing the necessary labor to maintain their businesses, it is hard to avoid the structural constraints imposed by employment. Giddens argues that “some social forces have an apparently

‘inevitable’ look to them” (p. 178) only because the consequences of avoiding participation in those social actions seem unreasonable to most people.

I have discussed several concepts within Giddens (1984) structuration theory: agency and structure, the duality of structure, material constraints, sanctions, and structural constraints. In order to clarify how these concepts relate to this study I will apply them to the four constraints facing Medicaid provider personnel in Texas.

A Structural Approach to Understanding Healthcare Worker Constraints

Structuration theory highlights how individual healthcare workers creatively cope with the challenges they face by transforming their work environment through local practices. Medicaid has never been accustomed to quick fixes or easy answers (Engel, 2006). However, structuration theory is a useful way to approach this study because it acknowledges the binding constraints facing healthcare workers without ignoring the impact individuals can exert within the system.

Applying Structuration Theory: Medicaid Policies and Protocols

Medicaid policies and protocols account for many of the material and structural constraints that challenge healthcare workers. For example, one of the clear challenges of working with Medicaid is being able to understand the intimidating mountain of policies and protocols Medicaid providers are expected to know. The fact that the manual is over 1100 pages is intimidating in its own right, imposing a material constraint based on the amount of time workers have to hunt down relevant information. Further, there are additional material constraints facing healthcare workers in terms of the protocols describing service codes needed for billing. Much of the provider handbook is

written in ‘legal’ language, and this may pose problems for some healthcare workers –requiring either extensive time to correctly interpret the billing protocol and/or access to people who can “translate” the handbook. Because correct interpretation of guiding rules is critical to enacting those rules and getting paid for services, providers may also face structural constraints dealing with rule misinterpretation and incorrect enactment of those rules in practice. Medicaid providers also face the sanctions of Medicaid as a federal and state funded program. While they may not consciously misinterpret the policies and protocols of Medicaid, Giddens (1984) makes clear that agency is not dependent on intentionality but rather on capability. As long as the rules are in place and available to healthcare workers, they will be held accountable for how those rules are interpreted and executed. If mistakes are made, those mistakes will still have material consequences for healthcare providers (e.g., over-payment of services, under-payment of services, and/or charges of fraud).

However, while Medicaid policies and protocols may constrain workers in material and structural ways and even sanction potential mistakes, Giddens (1984) reminds us that “structure is not to be equated with constraint but is always both constraining and enabling” (p.25). Thus, HSPs are also enabled by the rules and resources of Medicaid policies and protocols. For example, with access to the knowledge resources available within the Medicaid Provider’s manual, healthcare workers have creative fodder to support alternative interpretations of how policies and protocols should be enacted. Of course, Medicaid officials can withhold payment for services and reject a claim if they feel a provider has not accurately interpreted the

billing code needed for payment (sanctions). Yet, if Medicaid will only pay in 30 minute increments and a provider has given 50 minutes of service time, the provider might justify rounding up and billing for two 30 minute allotments, profiting from a subtle interpretation of this policy.

In addition, Medicaid providers do not come to the table empty handed. The policies and protocols of Medicaid may allow for alternative interpretations and enactments, but providers also have other resources available to them. They have professional relationships, educational expertise, and previous experience working with private insurance and/or Medicaid that they can bring to bear on how they interpret and enact Medicaid policies and protocols. For example, an office manager who has worked with Medicaid policies and protocols in a hospital environment may draw on these resources in a new job with a dental practice. Additionally, professional relationships can serve as a resource to Medicaid providers by giving them access to experienced professionals in their own field who have had experience working with Medicaid before.

Applying Structuration Theory: Values Toward Indigent Care

Scott, Corman, and Cheney (1998) use Giddens' (1984) model of structuration as a springboard to explain the dualistic relationship between identity and identification within organizations. This is especially important to understanding the impact of Giddens' ideas on the personal and professional values healthcare workers hold toward indigent care because identity is conceptualized as a structure of values, beliefs, and norms. These values, beliefs, and norms constitute the rules and resources (structure) organizational members draw upon in order to express their connection to or

identification with organizations and groups (agency). Because rules give guidance for behavior, when rules are communicated they are unavoidably interpreted as well. These interpretations of rules influence how people act. Thus, when we engage in the communicative process of identification we essentially interpret values that are then made part of particular identity structures and these structures of identity are drawn upon as we interact with others to express who we are. For example, when mental health caseworkers engage in counseling sessions with clients, they are enacting a network of meaningful behaviors (i.e., asking questions, listening empathically, taking notes, giving advice) that exemplifies their understanding of what it means to be a caseworker. How they interpret and express the values, beliefs, and norms that constitute the profession of “caseworker” then influence how they make sense of professional identity. This creates an ongoing and mutual dependence and influence between identity structures and how they are enacted (identification) and also provides subtle variations between individuals.

Scott, et al. (1998) recognize that we have multiple identities and multiple groups with which we identify. This means that it is common for the values, beliefs, and norms that make up our identity structures to support one another, but also to conflict, compete, and even clash. For this reason, these scholars suggest Giddens’ (1984) concept of *regionalization* as a productive way to conceptualize the interactions that take place between identity constructs. Regionalization refers to the “temporal, spatial or time-space differentiation of regions either within or between locales” (Giddens, p. 376). Scott, et al. argue that the various regions of rules and resources available to a person are regionalized or grouped together into structures of identities. Within the concept of

regionalization of identities, they utilize Giddens' concepts of form, character, span or scale, and offer four ways to conceptualize the interaction between multiple identities: overlapping and unique regions, front and back regions, identity size and position, and identity tenure.

Overlapping and unique regions. Overlapping and unique regions deal with the compatibility and conflict between various identity structures that make up an individual. Some constructs reinforce one another, overlapping mutually shared values, beliefs, and norms while others might conflict with each other. As both professionals with organizational attachments and as individuals with personal commitments, healthcare workers may feel comfortable at work sharing their personal opinions but they may also censor their remarks to each other or to Medicaid patients because of professional norms. In other words, they must negotiate the tensions between identities.

Front and back regions. Front and back regions describe the ability people have within a single identity to express a positive connection to a target of identification (identification) or a negative connection (disidentification). An example of this is a dentist who strongly connects with the ideal of helping people who cannot afford healthcare (and thus becomes a Medicaid provider), but is repelled by patients who are rude and unwilling to follow through on treatment recommendations.

Identity size. Identity size acts as an indication of how important a particular identity is to the individual and considers the “number of features encompassed by that identity” (Scott, et al., 1998, p. 316). *Identity position* expresses the relation of identities to one another, highlighting “which identities are central and which become more

peripheral over longer spans of time” (p. 317). This would suggest that if Dr. Smith, a pediatrician, chose to become a doctor but mostly did it because she didn’t know what else to do, then her professional identity would mean little and be relatively small compared with other identity structures. In contrast, if Dr. Jones gained personal satisfaction from pediatric work, depended on this job as a status symbol among friends, and also saw it as a way to enact personal religious commitments, then his professional identity would have greater significance and be relatively large in comparison to other identity structures.

Identity tenure. Identity tenure looks at the length of time a person has accessed a particular identity. Identity tenure is a factor in how entrenched particular identities become over time (Scott, et. al., 1998), and there are also practical reasons why particular identities may become entrenched and difficult to shed. Scott, et al. suggest that “sunk costs” may make it easier to maintain a particular identity. For example, an optometrist who has spent six months filling out forms and talking with Medicaid personnel to become a provider will not stop providing if things are getting a little frustrating with patients.

For healthcare professionals, the constructs of values, beliefs, and norms regarding indigent healthcare are regionalized within their personal and professional identities. This regionalization will be based on how they interpret and express attachment to such things as political preference, experiences with Medicaid patients or indigent groups, relationships with coworkers who share or disagree with their perceptions, and organizational memberships beyond the workplace. Based on the

historic clash between private practices and Medicaid, most professionals will probably feel some level of animosity toward the program. However, given the complexity of the identification process, this does not necessarily mean HSPs will disidentify with indigent healthcare as a whole.

Applying Structuration Theory: Organization and Healthcare Service Type

A third set of constraints that impacts how healthcare workers experience Medicaid comes from the rules and policies found within their own organizations. Healthcare workers are not in a vacuum. They have their own business policies and rules to guide the work they do and these things are influenced by organization type (e.g., private practice, public non-profit) and the type of healthcare service they provide (e.g., pediatrics, dental, mental health).

Workers face unique challenges based on in the organization's revenue source. For example, private practices must compete with other private practices for business. This is especially difficult for Medicaid providers because of the unavoidable material constraints placed on them in the form of lower reimbursements from Medicaid. However, private practices may create rules and policies (i.e., self-imposed structural constraints) to limit the number of Medicaid patients served and enhance their chance of survival in a competitive market. In contrast, public non-profit organizations are in business for indigent groups. They generally offer some kind of sliding fee payment program in order to make payments more manageable and this money is often subsidized by state and federal funding. Thus, they would not only accept Medicaid patients, but favor increasing the number of Medicaid patients they see in order to obtain state and

federal dollars. While a blessing, this guaranteed funding might also be a curse and lead to material constraints in the form of, for example, increased patient loads.

It is also important to look at the impact of healthcare service type on the kinds of rules and policies healthcare workers must work within. Medicaid pays different fees for different kinds of services, and the rate at which each healthcare service gets paid is also different. Dentists typically see patients once every 6 months while optometrists are scheduled on a yearly basis. Similarly, psychologists, counselors, and therapists see their patients several times a month and commonly have ongoing prescriptions that complement the services they provide. To Medicaid policy makers, these service-type policies that govern what each healthcare provider is required to do are viewed as structural constraints. However, when experienced by healthcare service workers, these policies are largely out of their control which makes them material constraints. Thus, HSPs may not be able to change the policies but they do have alternatives of adapting their own internal policies to deal with more localized material constraints they experience based on the type of service they offer.

Applying Structuration Theory: Pressures of Medicaid Patients

Structuration theory also provides interesting insights into how provider personnel may cope with the pressures they face from Medicaid patients themselves. Workers, especially frontline staff, deal with patients face to face. These staff members are in charge of collecting the insurance information and often for billing Medicaid, so they have the potential to be inundated with patient concerns and emotions. Because many of the pressures healthcare workers face from patients are interpersonal, it makes

sense that most of the choice alternatives would include ways to avoid negative interactions (which would constitute overt or subtle structural constraints). It would make sense that healthcare workers have rules and/or policies (perhaps including sanctions) in place to reduce and attempt to eliminate negative altercations with patients.

In summary, structuration theory acknowledges the challenges imposed on workers by their environment without losing sight of individual choice in determining how those constraints play out. I have shown how workers are limited by the policies and protocols of the Medicaid system itself, by the values that guide their behavior towards indigent healthcare, by the more localized rules and policies of their own business and healthcare service type, and by the interpersonal interactions they have with Medicaid patients. However, healthcare workers are also enabled by those very structures as well. Local interpretations of particular rules and values have the potential to bend these constraints in ways that support rather than conflict with daily work goals, organizational objectives, and professional identities. In other words, healthcare workers are not just passive victims caught within a web of constraints. They are active (either conscious or unconscious) participants whose activities transform and reproduce the constraints they all experience. To better understand how HSPs make sense of these challenges and how those sense-making strategies influence their ability to work in such a complex work environment, I propose the following two research questions:

RQ1: How do healthcare service workers make sense of a complex work environment where they are constrained by (a) the policies and protocols of the Medicaid program, (b) national, professional, and individual values associated

with indigent care, (c) rules and policies associated with specific organizational forms, and (d) the pressures presented by Medicaid patients themselves?

RQ2: How do the sense-making strategies of healthcare service workers help and/or hinder their ability to cope as professionals within such a complicated work environment?

Sensemaking and Professional Identity

While structuration theory focuses on the connection between individual actions and larger social structures and vice versa, Karl Weick's (1995) sensemaking works to describe the processes that structure how we give meaning to our individual actions and how we use that meaning to guide how we see ourselves, the world around us, and the choices we make. Sensemaking is the process of giving meaning to otherwise meaningless events and actions. Such meanings affect how we act and/or structure our environment. However, sensemaking is different than structuration theory in an important way. Specifically, sensemaking describes the process that brings about the rules and resources that make up social structure whereas structuration theory describes how agents enact social structures in order to express their individual agency and how those ongoing actions maintain and transform society. Sensemaking is rooted in identity construction, happens retrospectively, occurs in an enacted environment, requires social interaction, is ongoing, focuses on extracted environmental cues, and is less interested in accuracy than it is in plausibility.

Sensemaking: Rooted in Identity

Identity construction is a critical part of the sensemaking process because “sensemaking begins with a sensemaker” (Weick, 1995, p. 18). Weick (1995) argues that individual identity is situationally constructed during social interaction and shapes the kind of ‘sense’ that is made from those interactions. In other words, we know who we are based on what we are doing, where we are doing it, and who we are doing it with. For example, a dental assistant takes x-rays of a patient’s mouth, works in a clinic or practice with dental equipment, and tells patients what to do while also taking instructions from the dentist. Interacting with other people in this way constitutes what it is to be a ‘dental assistant.’ How each person interacts in those social relationships makes up unique professional identities for each individual who becomes a dental assistant.

These constructs of meanings constituting individual and professional identity act as filters through which we make sense of our own actions. As a result, we make sense of ourselves by seeing the world through multiple layers of previous social interactions. These layers of identity prioritize the actions and meanings we pull from the ongoing flow of everyday experience. In effect, our identity arises from how we make sense of our own actions (and social interactions) specific to a particular environment, but also biases how we make sense of them. Akin to the chicken-or-the-egg dilemma, it’s difficult to tell which came first, the sensemaking or the identity, as each reacts to and depends on the other in an ongoing cycle of meaning making.

Sensemaking: Retrospective and Enactive

When we engage in sensemaking, we look back upon a stream of events and actions that have already transpired in order to give meaning to them. Weick (1995) argues that most of us distinguish experience as distinct events rather than a continuous flow of experience “but the only way we get this impression is by stepping outside the stream of experience and directing attention to it” (p. 25). The ongoing stream of experience which is “reality” can only be understood retrospectively. By looking back on past experiences, particular cues stand out (determined by which identity construct is most salient to the situation and/or interaction), and can then be distinguished as something apart from the continual flow of experience, categorized, bounded, and thereby imbued with meaning. In this way we literally create sense (or meaning) out of otherwise meaningless experiential fodder. As a retrospective act, meaning making is not static but is constantly changing based on the kind of attention that is given to the experience(s) in question, the ongoing activities of the moment, and our memory of the event(s) receiving attention. Weick (1995) argues that “meaning is not ‘attached to’ the experience that is singled out. Instead, the meaning is in the kind of attention that is directed to this experience” (p. 26). For this reason, healthcare workers may look at the experience of working with Medicaid patients differently during comparatively stressful periods of work versus more comfortable periods. They may connect their experiences with abuses they’ve noticed or with opportunities given to people that have legitimate needs. These shifting meanings point to the equivocal or multiple meanings associated with our experiences.

Sensemaking is rooted in action. Weick (1995) argues that “action is a precondition for sensemaking” (p. 30). *Enactment*, as a concept, encompasses the act of communicating the meanings we make with others and thereby constructing the environment within which we live. According to Weick, “there is not some monolithic, singular, fixed environment that exists detached from and external to these people...they act, and in doing so create the materials that become the constraints and opportunities they face” (p. 31). Such language is reminiscent of the overview of structuration theory presented earlier. Weick openly connects sensemaking with structuration theory when he identifies the concept of sensemaking, as a process of enactment “that creates the objects for sensing or the structures for structuration” (p. 36).

Sensemaking: Social and Ongoing

Weick (1995) argues that sensemaking is a process whereby meaning is co-created through social interaction. It is through interacting with others that meaning emerges. Because talk typically mediates social interactions, this usually becomes the preferred text by which to enact and/or examine sensemaking activities. However, talk is not the only means whereby individuals can engage in social interaction, and alternative ‘texts’ could also include any meaningful behaviors or talk that constitute a “shared meaning,” “equivocal meanings,” or “overlapping views of ambiguous events.” Weick’s conceptualization of social interaction, however, has enough scope to accept even individual sensemaking as a social experience wherein the individual interacts with an imagined audience and shapes how the meaning is created by catering to its imagined reaction.

When people engage in sensemaking, they effectively step “in the middle” of an ongoing act of social meaning, bringing with them past constructs that shape what kinds of meanings they are bound to see and situating themselves within a manufactured beginning to the sensemaking process. Such ‘beginnings’ are manufactured through language as individuals co-construct the boundaries of conversations and activities. A good example of this is the interviewing process that occurs between caseworkers and new patients within the mental health field. As caseworkers ask particular questions in order to solicit responses, those questions frame the boundaries of responses. Closed questions that solicit a yes or no answer from the patient manufacture different boundaries on responses than open-ended questions that leave the patient free to respond to a given topic in their own words. Similarly, additional probing questions can narrow or expand the boundaries of responses within an interview.

Sensemaking: Extracted Cues and Plausibility

Weick argues that we attach meaning to raw experience based on the cues or highlights we extract from the ongoing flow of activity making up daily life. These extracted cues bracket our ongoing experience into individual experiences and represent “familiar structures that are seeds from which people develop a larger sense of what may be occurring” (p. 50). For example, a front desk worker may have a preference towards making conversation with patients when they come in for appointments. If a particular patient gives short answers rather than engaging in open conversation, the worker may tell their co-workers that this person was rude to them. The patient’s lack of engagement in open conversation was the primary cue that bracketed this interaction as something

significant and separate from the ongoing flow of daily activities. Extracting a different cue from this interaction (i.e., physical appearance, presence of children, accent, etc.) could yield different meanings. Even if the same cue was highlighted, the worker could have attributed the short responses to shyness, a language barrier, or even illness by applying plausible meanings from similar experiences.

The possibility of more than one possible meaning reminds us that “the prefix *sense* in the word *sensemaking* is mischievous” because it suggests there is something “out there to be registered and sensed accurately” (Weick, 2005, p. 54). However, at its core, sensemaking “is about plausibility, pragmatics, coherence, reasonableness, creation, invention, and instrumentality” (p. 57). It is less about a judgment of accuracy than it is about whether or not the sense that is made is reasonable to the people doing the sensemaking. For this reason a great deal of what happens in sensemaking is centered on each individual involved in this process. This is one of the reasons why there are equivocal meanings to explain the same situation – each meaning runs through the filter of life experiences, values, beliefs, norms, and habits that make up each person’s own unique view of the world.

Weick’s (1995) sensemaking focuses on the constitutive processes by which workers bring about the identities and other social structures that can become benefits and barriers to the work they do. Particularly, it allows us to get a closer look at the meaning-making process healthcare workers use to determine who they are and what they do as professionals.

Making Sense of Healthcare Worker Identity

As mentioned earlier, sensemaking does not occur in a vacuum. Weick (1995) believes individuals shape meaningful experience from extracted cues and those meanings then become the basis for how they see themselves. He argues that “people learn about their identities by projecting them into an environment and observing the consequences” (p. 23). Our identities emerge from the meanings associated to our relationships and interactions with others through sensemaking. This identity construction then influences how meaning is made in future interactions. According to Weick, in order for this process to work, individual cues must be extracted from an otherwise meaningless stream of events, giving focus to particular actions over others. These “brackets and punctuations shape, modify, and give substance to whatever other activities the person confronts” (p. 36).

Through Weick’s (1995) conceptualization of sensemaking, it is clear that we shape the social structures we experience at even the most fundamental levels. Before we have rules and resources by which to structure our sense of identity as individuals and professionals (Scott, et. al., 1998), we bring those rules and resources into existence and imbue them with meaning by retrospectively carving them from the ongoing flow of our own lived experiences. Essentially, we participate in selecting and upholding the meanings of the constraints we experience (Weick, 2001). For healthcare providers, this means that even before they have rules and resources by which to structure their identities, they have already used their identities to bias particular cues and imbue them with singular meanings which shape how they make sense of the constraints they

experience. Because there are equivocal meanings available by which to make sense of their experiences it is not predetermined that healthcare workers will always make sense of their experiences as constraints. Such meanings will necessarily be tied to how healthcare workers see themselves and the work they do. For example, in making sense of a new patient in the office, a front desk worker will be especially attuned to making sense of cues related to scheduling and payment, while a pediatrician would find cues related to following a particular treatment plan more salient and meaningful. This suggests that while some healthcare workers may make sense of their experiences as constraints based on which self they use to create meaning, the same experience may not be viewed as a constraint from every healthcare worker.

Though different identities are relevant throughout the sensemaking process, professionals participate in shaping their own perceptions of what it is like to work with Medicaid patients and the Medicaid program because of how they see themselves. These perceptions are shaped by identity, by the context, and by interaction. These multiple influences on the sensemaking process lead to the final research question:

RQ3: How do the meanings that emerge from sensemaking communication shape how healthcare service providers see themselves as professionals and how they view the work they do?

Healthcare workers face many challenging constraints as part of their work with the Medicaid program as healthcare providers. In this chapter I have outlined four significant constraints (Medicaid policies and protocols, values related to indigent care, business rules and policies, and Medicaid patients). I have introduced Giddens' (1984)

theory of structuration and Weick's (1995) conceptualization of sensemaking and discussed their potential for helping us better understand how healthcare workers cope. Finally, I have introduced three research questions that will shed light on how these professionals view their complex work environment, how different sensemaking strategies might influence their ability to perform work, and how the meanings that emerge from their communicative interactions shape how they see themselves and how they view their work. In the next chapter I will review the methods I followed in conducting this study.

CHAPTER II

METHODS

In this chapter, I discuss my methodology for this research study of Texas Medicaid healthcare providers. I begin by reviewing my personal interest and motivation for studying Medicaid providers in Texas. Following this, I discuss the national perceptions of welfare care generally and the Medicaid program specifically. Finally, I describe the interviews I used to collect my data and the specific questions within those interviews, ending with the procedure I followed to conduct this research study and analyze the data.

Explanation of Interest

I first became interested in the challenges facing healthcare personnel who worked with Medicaid because of my family's experiences with the Medicaid program. While earning my MA in Missoula, Montana, our family qualified for Medicaid. When we moved to Texas for my doctoral degree, my wife and I did not qualify for Medicaid but our children were on the program. In making the transition from Montana to Texas, several things changed in our family that gave us greater exposure to the Medicaid program. First, our oldest son was diagnosed with bipolar disorder a year prior to leaving Montana. When we moved to Texas we were immediately involved in getting him qualified for Medicaid services to help cover his \$800/month prescription needs and additional doctor appointment costs while I worked on my PhD. We soon realized how difficult it was to get him enrolled and to find qualified mental health professionals willing to accept Medicaid. We made dozens of phone calls to local psychiatrists and

psychologists with no success. It was quite a shock. Having so easily accessed these services in Montana, we had no idea how spoiled we had been to have a child psychiatrist and a neurologist in the same town who were more than willing to take Medicaid. Our experience enrolling our children in Texas Medicaid exposed us to all the aggravating ‘speed bumps’ commonly associated with government bureaucracies. Thankfully, after several months we were able to find a clinic that worked on a sliding fee scale and also accepted Medicaid. This experience got our attention and prompted several long “venting” sessions where my wife and I talked through all our frustrations in dealing with the Texas Medicaid system. It also got us thinking about what could or should be changed in the system to make it better. This was when I first began to seriously apply what I had learned in my field to the Medicaid program as an organizational system. It was informal, but the insights I gained through conversations with my wife over our frustrations planted a seed of interest in how this massive system worked.

Second, our family was growing. When we moved to Texas, our three children were fairly young (6, 4, and 2) but it wasn’t long before we were registering them for school. With school came required medical visits and as they got older came additional reasons to get them into a variety of healthcare professionals for services using Medicaid (i.e., glasses, cavities, well-child appointments, etc.) Two more children came into our family during our first and fourth year in Texas. These experiences began to shape our opinions of Medicaid from a patient’s perspective. We dealt with frustrating Medicaid personnel in person at the Health and Human Services Department and over the phone

during scheduled recertification appointments. Without knowledge of our background, education, or family values, healthcare professionals largely treated us the way they treated every other Medicaid patient – sometimes treated no differently than any other patient but at other times treated with pity, rudeness, and even animosity. At all times, we felt grateful for the financial help, but embarrassed to use it in public. Being subject to the long lines, crowded waiting rooms, reproving glances from office staff, and stereotyped assumptions that needled their way into the questions and comments of professional staff, we were treated to all the financial benefits and social drawbacks every other Medicaid participant experienced. Some of our negative experiences with Medicaid personnel and healthcare professionals were so potent and raw that for several years it was difficult to even acknowledge that anyone else but the patient deserved attention. However, as a doctoral student studying organizations, conflict, and issues of professional identity and organizational identification on a daily basis, it became important for me to join my intimate involvement in the Medicaid program with the scholarship of my graduate program.

One experience in particular took my mind off my own challenges with Medicaid and turned me to the challenges facing healthcare professionals. I had taken my children to the dentist – the first dentist in the area we could find that would accept Medicaid. It was our initial visit to the office and I was immediately taken back by the number of parents and children waiting to be seen. The dentist saw primarily Medicaid patients, and the waiting room could easily hold twenty to thirty people. That room was filled to capacity and the twenty plus patients (who we joined) were seated on wooden benches

that lined the sidewalk outside the clinic or walking around waiting for their name to be called. My wife had taken our two oldest (ages 9 and 7 at the time) earlier that day, had waited two hours, and then returned home for an appointment. I was on the second shift of the wait and returned to our 'place' in line with my children to wait another hour before being called in.

The inside of the clinic was nearly as eye catching as the outside. While the walls were playfully painted in bright colors and designs for the children, it was easy to see why the waits were so long. One person ran the front desk with only one dental assistant and one dentist working the clinical area. Beyond the waiting room, the dental assistant and dentist were actually running between patient booths to do their work. Once we sat down, the dental assistant quickly checked the kids for cavities and after a few minutes invited the dentist in. After quickly explaining her findings, the assistant was out of the booth and on to the next patient. In our booth, the dentist seemed out of breath and openly stressed as he quickly ran through a routine of tasks on my daughter's teeth. I began to register that this man was under quite a bit of pressure and I asked him what it was like to work there. Without taking his eyes off his work, he told me that it was always this busy. I asked if he ever got vacation time so that he could take a break and he laughed and said "We don't get vacations here." I walked out of that appointment with a new perspective. Not only was I "in the middle" feeling pressure over dealing with Medicaid program personnel and healthcare providers for my kids, but healthcare providers themselves were caught in the middle as well.

Seeing the amount of pressure this man was under opened my eyes to the kinds of potential pressures facing all Medicaid providers in the work they do. I began to approach medical appointments with a new interest in learning what it was like for frontline staff and medical professionals to work with Medicaid. Eventually, this interest matured into a scholarly curiosity wherein I could more formally investigate the pressures facing Medicaid providers from several different healthcare fields.

My own experience using Medicaid and interacting with doctors and other healthcare providers has sensitized me to the multi-faceted nature of state and federally funded healthcare. Having experienced Medicaid as a patient and as a parent, I am aware of the pitfalls and challenges facing those who come asking for services. What's more, having spent so much time with healthcare providers untangling the bureaucratic policies and provisions of the program, I am cognizant of the frustrations facing healthcare providers as they work with patients to make the program work. I have seen the dedication of many healthcare providers who have taken substantial financial "hits" in order to smooth out unexpected barriers so our children could get the care they needed. Such dedication speaks to the individual and professional values guiding Medicaid healthcare providers. When all is said and done, it really is the healthcare providers who willingly negotiate the murky waters of the Medicaid program that deserve the final credit for getting healthcare to indigent groups. Without their willingness to be in "the middle" of so many challenging personal and professional constraints, the Medicaid program might well have collapsed within its own contradictory policies and practices long ago.

Context: History of Medicaid in the United States and Texas

Medicaid was passed into law by the United States Congress as part of the Title XIX Social Security Act of 1965. According to Engel (2006), the idea of federally funded healthcare was conceived of long before Medicaid's actualization as a federally mandated state program. Early presidential advocates for federally supported healthcare stretched back as early as Teddy Roosevelt's Progressive Platform of 1912 where he advocated for "the union of all the existing agencies of the Federal Government dealing with the public health into a single national health service" but the idea didn't take hold (Ashbrook Center for Public Affairs, 2008). Years later, FDR was also defeated in his efforts to establish a universal government healthcare program. Ultimately, it wasn't until Lyndon Johnson's war on poverty that Medicaid was added as an afterthought to Title XIX, a program with the primary intent of creating Medicare as a government supplemented healthcare program for the elderly (Engel, 2006).

The Medicaid program runs at both the federal and state levels. At the federal level, Medicaid is administered by the Center for Medicare and Medicaid Services under the jurisdiction of the Department of Health and Human Services (Warner, Jahnke, & Kimbell, 2005) Each state is required by law to have a Medicaid program and the federal government provides matching funds to offset some of the financial obligation. As an entitlement program, Medicaid must admit anyone who meets the eligibility requirements, based on "whether you are pregnant, disabled, blind, or aged; your income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether you are a U.S. citizen or a lawfully admitted immigrant" (Centers for

Medicare and Medicaid Services, 2010). According to Warner, et al.'s (2005) Code Red report on healthcare in Texas, in 2005 Medicaid covered “one-fifth of the children in the U.S. and pays for one-third of all childbirths, two-fifths of all long-term care costs, one-sixth of all pharmacy costs, and half of states’ mental health services.” (p. B-3)

The State of Texas joined the Medicaid program in 1967 (Warner, et al., 2005) and now has 3.27 million people enrolled across the state (Texas Health and Human Services Commission, 2010) with a potential increase of 1.5 million by the year 2015 (Garrett, 2010). With nearly 27% of Texas residents uninsured, representing the highest percentage in the nation (Mendez, 2010b), the federal government covers two-thirds of the cost of the Medicaid program in Texas (Warner, et. al., 2005)

Context: Perceptions of Medicaid and Welfare in the United States

Marmor, Mashaw, and Harvey (1990) argue that Americans embrace two contradictory ideals regarding healthcare provision to the poor: “rugged individualism” and “community responsibility.” The ideal of “rugged individualism,” aptly personified within the independent and self-reliant cowboy persona, expresses the worldview that individuals are responsible to make their own way in the world. As a result, those who are trapped in poverty should be willing to take responsibility for their own condition and work towards self-reliance and independence from government assistance. Marmor, et al. argue that “rugged individualism” is a defining part of the American identity and has influenced the Medicaid program by restricting the amount of assistance those on welfare receive and/or restricting those who qualify for aid to only the most needy populations (i.e., in Texas adults must meet a standard of 17% of the Federal Poverty

Level in order to qualify for Medicaid according to the Code Red Report, 2005). This ideal has had communicative implications that influence how people think about those who qualify for Medicaid. Interestingly, Engel's (2006) chronology of the Medicaid program in the U.S. notes the conscious change Medicaid policy makers made from labeling those who receive healthcare through government funds (i.e., Medicaid) as "recipients" to labeling those on Medicaid as "beneficiaries" in order to downplay conservative fears that the poor may come to see government healthcare as an expectation rather than a privilege.

While "rugged individualism" is a powerful ideal within the American psyche, Marmor, et al. (1990) argue that taking care of each other is also part of what it means to be "American." For example, while FDR's plan to create universal healthcare (Engel, 2006) may not have had the favor or support of professional organizations like the American Medical Association, it was one of the early attempts at addressing the growing medical needs of an increasing indigent population. Similarly, Lyndon Johnson's war on poverty (where "poverty" was defined as a unique *societal* illness) is a similar expression of community responsibility and resulted in the construction of community health centers. Individual healthcare providers provided services to the poor free of charge long before Medicaid was instituted as a federal/state program (Engel, 2006) and the value of providing service to community members has continued to motivate healthcare workers in spite of financial losses (Biles, 2007). Marmor, et al. (1990) argue that our patchwork of contradictory healthcare policies, stubborn bureaucratic categories, and ongoing stereotypes of who the poor are and what they

deserve is largely due to compromises, trade-offs, and legislative victories that result from the ongoing political and private tug-of-war between these competing American values.

In 2005, the Kaiser Family Foundation sponsored a national survey of American attitudes toward the Medicaid program. The survey found that 56% of respondents had a personal friend or family member that was or had been on Medicaid and 78% said they would enroll in Medicaid themselves if they financially qualified for the program. Furthermore, 81% of Democrats, 79% of Independents, and 61% of Republicans qualified Medicaid as a very important program in the U.S. Even among the more conservative Republicans surveyed, 65% said they would oppose federal cuts to the Medicaid program. This survey demonstrates that a majority of the American public is largely in support of the Medicaid program regardless of party affiliation. While acknowledging the tension between ‘rugged individualism’ and the need for ‘community’ outreach toward those in need, a majority of people in our country see Medicaid as a valuable program that should continue to have financial support through federal and state tax dollars.

Methods Overview

This study began by asking three research questions:

RQ1: How do healthcare service workers make sense of a complex work environment where they are constrained by (a) the policies and protocols of the Medicaid program, (b) national, professional, and individual values associated

with indigent care, (c) rules and policies associated with specific organizational forms, and (d) the pressures presented by Medicaid patients themselves?

RQ2: How do the sense-making strategies of healthcare service workers help and/or hinder their ability to cope as professionals within such a complicated work environment?

RQ3: How do the meanings that emerge from sensemaking communication shape how healthcare service providers see themselves as professionals and how they view the work they do?

Several factors influenced the study design. Medicaid is an enormous system that impacts nearly every healthcare profession in the U.S. regardless of the differences in services they offer. Healthcare professionals within that broad sweep of professions also experience Medicaid in different ways due to the duties they perform (e.g., front desk workers over billing experiences different aspects of Medicaid than would an optics professional that works with Medicaid patients face to face). In addition, how organizations receive funding for those services (e.g., private vs. public non-profit) also has an influence on the kinds of pressures that healthcare workers experience as part of the work they do with Medicaid. In order to account for the unique perspectives resulting from the various combinations of healthcare service type, work duties, organizational funding, etc., I chose to design this study with as much breadth as possible. I approached multiple organizations in a variety of healthcare fields in order to interview as many different kinds of workers as possible within each respective organization. By so doing, I hoped to provide as many unique perspectives on how

healthcare workers engage and experience Medicaid as possible. Because of the number of organizations and professional perspectives I hoped to represent, I needed a method of data collection that would allow me to move between organizations efficiently and still give each worker a clear individual voice. Further, because I was interested in hearing how respondents made sense of their work environment, professional identities, and experiences, they needed to be able to talk, edit, and rethink their experiences in a way that I could capture those reflective processes as they were emerging. For these reasons, individual interviews were a natural choice to collect the data I needed for this research study.

While I was interviewing, I took down additional notes of our conversation and used probing questions to solicit more detailed responses from participants. I kept a log of ideas I had throughout the interviewing process that worked as my initial analysis of the data. This allowed me to pursue additional lines of interest during subsequent interviews that coincided with particularly interesting question responses. After conducting all of my interviews, I sent off the data to be transcribed by an outside transcriptionist via e-mail, audio-checked all the transcriptions line-by-line to ensure accuracy with the actual interview recordings, and then began the formal analysis process.

For the formal analysis, I used the QSR NVivo 7 software program to organize the codes, categories, and themes that emerged from the raw data transcriptions. As I was reading through the transcripts I used the software early on to identify emerging categories and attach descriptive quotes from the data file to them. When I had finished

moving through all the transcribed interviews, I returned to the categories and took a second look at the data files attached to categories that seemed similar to one another. Using the software merge function, I merged data files together that seemed to express similar themes under unified thematic categories that more accurately expressed the similarities I had found within the text of participant responses. I then converted the files for use in Microsoft Word during the ongoing analysis of this data.

Once I had received positive feedback on the write-up of emerging themes that adequately answered my original research questions from my dissertation chair, I sent e-mail copies of the resulting themes to the workplaces of each worker who participated in this study. In this email I included all the findings I had written, putting some of the headings in layman's terms to make it more understandable to a lay audience. The document I sent was 65 pages in length. I consciously chose to send a 65 page paper rather than providing participants with an executive summary so that they could see how their words were being used in context. I offered to supply them with their unique pseudonym if this was requested via email (see Appendix F). I requested participant feedback on the accuracy of the themes I had identified as emerging from the text of the data (see Appendix E). I gave them 14 days to respond to me via e-mail with any changes, recommendations, and/or concerns with the results of this study (see Appendix F) but did not receive a response from any of my participants. This lack of feedback may suggest that participants were intimidated with the prospect of reading 65 pages of research findings. However, a lack of response may further demonstrate the tremendous pressure each provider is under, leaving little time to respond to my inquiries.

Procedure

In October of 2008, I received institutional review board authorization from Texas A&M University to begin interviewing Texas Medicaid provider personnel using a semi-structured interview approach. In order to identify a pool of possible interview participants, I began by making cold calls to healthcare providers in the area. During the initial call I asked them if they accepted Medicaid. If they did, I proceeded to describe my research study. After telling them that I was interested in talking with healthcare providers about what it was like for them to work with Medicaid, I asked if they would be willing to allow me to conduct some interviews with them and/or their staff. Thus, many of the initial participants were a convenience sample of those who responded positively to cold calls. Other participants were gathered using a snowball data gathering method based on referrals following initial interviews.

All interviews were audio-recorded in digital format. Between October 2008 and July 2009 I interviewed all participants at their workplaces at a time and day of their choosing. Prior to each interview, I provided each participant with a signed copy of the consent form (Appendix D) and gave them time to read and ask questions. I kept a second copy of the signed consent form for my own records. Participants were told they would receive no immediate benefits from participating in these interviews but they were promised a chance to review the findings of the study when it was complete. They were assured that their personal information would be kept confidential.

Interviews were scheduled for 15-20 minutes, but there was a great deal of variation in actual interview lengths. The shortest interview was 6 minutes due to work

interference (only five interviews were less than 20 minutes) while the longest interview was 50 minutes. Most interviews were between 20 and 40 minutes and totaled nearly 18 hours of recorded interviews as a whole. Once recorded, interviews were saved on two computer hard drives in separate locations and e-mailed to a transcriptionist in California. Once transcribed, I received the typed interview via e-mail. The final transcribed file of all 36 interviews comprised 366 pages of single-spaced text. Prior to formal analysis, I reviewed all the interviews by listening to the audio while reading along with the transcribed text to ensure the accuracy of each transcription. While time consuming, I was also able to write down initial impressions about the interviews that would help me during my formal analysis. All personal names were entered into the transcriptions exactly as recorded, but were changed during the final writing of the results section to preserve confidentiality.

As with any qualitative study (Lindloff & Taylor, 2002), analysis accompanied each step of the research process. During the actual interviews, I took field notes of significant ideas and topics from our recorded conversations in order to ask additional probing questions to each participant. Similarly, after each interview was transcribed, I continued to take notes of themes that emerged from the text, comparing them with other transcriptions as they were made available to ensure the themes were consistent with the lived experiences of the participants I interviewed. During the interviewing stage I took time periodically to write about my impressions which helped me later to identify important themes in the data. Some interview participants did not have time to answer

all the demographic and organizational questions during the actual interview, so I chose to call them via telephone after the interview to get the information I was missing.

The primary analysis took place after all the interviews were transcribed and reviewed for accuracy. During this stage of analysis “the analyst usually goes through the texts...line by line and marks those chunks of text that suggest a category” (Lindloff & Taylor, p. 219). I used the QSR NVivo 7 qualitative research software to accomplish this line by line review and categorization of the data. It allowed me to highlight a particular passage in an interview and group that passage with other similar responses without having to constantly copy and paste the text I was highlighting into separate word processor documents. This analytical tool also maintained a link between categorized data and the conversational context that helped to give those comments meaning.

In order to ensure the integrity of the categories that emerged from the data, I applied a modified grounded theory approach (Lindloff & Taylor, 2002). I looked for themes in the interviews that demonstrated how healthcare workers made sense of themselves and the complex environment in which they worked. At multiple times during the formal analysis, I broke away from the data to write about impressions and ideas that came to mind. I wrote about the characteristics and relationships between themes, experimenting with categories and codes that accurately addressed the patterns I was finding.

As themes emerged from the interviews, I collected them under files based on the subject of the theme and went back to the text of interview data to see if it supported the

emergent theme. In the beginning, I focused on generating as many categories as seemed to be emerging from the data. However, through constant comparison between the categories and the data, it quickly became apparent that some of the categories had significant overlap with one another. In such situations it made sense to combine similar categories under a single heading. Through the process of constant comparison, other categories held constant or dropped away entirely. When I found that the same codes continued to emerge from the data and became repetitive, I knew I had struck on solid theoretical categories. I then eased away from in-depth interviewing to focus my attention on analyzing, writing about my findings, and connecting what had emerged with current bodies of research. Each participant was given a pseudonym which started with a different letter of the alphabet than their own name. The write up of this study utilized these pseudonyms in place of actual names to preserve the confidentiality of each participant.

Participant Demographics

During my interviews, I spoke with a total of thirty-six healthcare workers who represented four major healthcare fields. Eight participants came from the dental field, four from pediatrics, nine from optometry/optics/ophthalmology, and fifteen from mental health. Of those participants, eight were men and twenty-eight were women. In terms of ethnicity, twenty-two of my interview participants were White/Caucasian, eight were African American, two were Asian Americans, and four were Hispanic.

I interviewed healthcare professionals from a total of eleven different private practices and public non-profit clinics. The dental professionals I interviewed

represented three dental organizations, two that were private practices and one that was a public non-profit clinic. The pediatric professionals came from a single public non-profit clinic. Optometry/optics/ophthalmology professionals came from one private ophthalmology practice, one private optometry practice and one private optometry/optics practice. Professionals from the mental health field represented three private practices and one public non-profit clinic. In total, sixteen participants came from the eight private practices and twenty participants came from the three public non-profit clinics. In terms of occupation, twenty-two of those I interviewed would qualify as some kind of clinical professional (i.e., nurse, optics technician, caseworker, doctor, dentist, dental assistant, psychologist, counselor/therapist). Fourteen of the participants I interviewed were office professionals (i.e. front desk workers, office managers, business directors). Six individuals I interviewed spent significant time in both clinical and office-related tasks within their respective organizations and seven I interviewed were clinical professionals (i.e., doctors, dentists, psychiatrists, or counselors/therapists) who owned their businesses and thus had supervisory authority over office activities.

Method of Inquiry and Instrument

In this study I used an interview guide to conduct semi-structured interviews with Texas Medicaid provider personnel. According to Lindloff and Taylor (2002), “interview guides...consist of groupings of topics and questions that the interviewer can ask in different ways for different participants” and typically allows for considerable flexibility for both the interviewer as well as the participant (p. 195). Through an

informal dialogue, their lived experiences as Texas Medicaid providers emerged naturally allowing participants to maintain control over the flow of conversation.

My interview guide contained fourteen questions (Appendix A). The initial questions (1-3) were used to put participants at ease and to create a context for the rest of the interview by collecting information on position and tenure, organizational demographics and characteristics, and the organization's history working with Medicaid ("Tell me a little about yourself," "What is your job title here?" "How many patients do you service?"). Questions 4, 5, and 10 initiated a discussion over the constraints healthcare workers faced from Medicaid policies and protocols ("What's it like to work with Medicaid here?" "What are some of the rules you have to follow to work with Medicaid?" "What's it like when you talk/interact with Medicaid personnel?"). Question 6 targeted the individual and professional values influencing how healthcare workers felt towards indigent care ("How do you feel about providing healthcare to those on Medicaid personally? Professionally?"). Questions 7 and 8 invoked discussions about the constraints and benefits of business rules and policies related to Medicaid ("Have there ever been times when you've had to adjust the way you run the office/do business to make things work out with Medicaid? Tell me a time when this has happened," and "What kinds of business policies do you have that make it either easier or more difficult to work with Medicaid?"). Questions 9 and 11 invited participants to talk about their experiences working with Medicaid patients ("What's it like to work with Medicaid patients themselves?" "Would your work be different if you only serviced people with private insurance?"). I was also interested in understanding whether

healthcare providers had considered dropping Medicaid and, if so, what had prevented them from doing this, in the hopes that it might give participants latitude to talk about issues they had not mentioned in previous questions. Question 12 (“Have you thought about NOT servicing Medicaid patients?”) applied to the decision makers/owners only and was easily excluded from discussions with frontline workers. Lastly, questions 13 and 14 helped worker make suggestions and visualize changes on how to improve Medicaid policies and patient interactions from their perspective as healthcare providers.

Interviewing has been a productive means of getting at the processes of structuration that contribute to organizational policies (Kirby & Krone, 2002) and institutional norms (Sherblom, Keranen, & Withers, 2002). Sense-making itself is dependent on collaborative “talk” (Weick, 1995), framed as “interview talk” (Larson & Pepper, 2003, p. 537), highlighting the interview process as a productive way for people to make sense of themselves and their actions. Talk is a form of action that allows us to make sense of ourselves and our environment (Weick, 1995), making interviews a productive window on how organizational members make sense of who they are, what they do, and the connection between individual meanings and larger social structures.

Collecting a diverse corps of participants from myriad backgrounds provides great breadth and internal rigor to this study while interviews allowed participants to retain their individuality and self-expression. Being able to introduce breadth while maintaining qualitative standards allowed this study to more fully represent the daily complexities healthcare workers cope with generally while still being able to comment on common challenges or perceptions shared by healthcare personnel with similar job

functions or in the same service field. In the next chapter I will discuss the themes that emerged from these interview data with Texas healthcare provider personnel.

CHAPTER III

INTERPRETIVE FINDINGS

This chapter will consider results relevant for the research questions posed in Chapter I. The first research question asked: *How do healthcare service workers make sense of a complex work environment where they are constrained by (a) the policies and protocols of the Medicaid program, (b) national, professional, and individual values associated with indigent care, (c) rules and policies associated with specific organizational forms, and (d) the pressures presented by Medicaid patients themselves?* In responding to this research question I will discuss the themes that emerged from the data for each of these four constraints in turn. In reporting the interpretive findings of this study pseudonyms have been used in place of actual names to preserve individual confidentiality.

Medicaid's Policies and Protocols

Healthcare workers made sense of Medicaid policies and protocols in two ways. First, they made sense of Medicaid's policies and protocols as something they had to learn without help from Medicaid personnel. Second, they framed Medicaid as better by comparison – better than it used to be or better than the policies and protocols of private insurance groups with which they worked.

No Help From Medicaid

Healthcare workers believed they had very little support in learning how to work with Medicaid policies and protocols – essentially they were left to either sink or swim. Workers didn't feel they had enough support from Medicaid personnel when they had

questions and/or concerns about how to bill claims. For example, Charla, a self-employed therapist and counselor, described herself as being caught in “a mess of a maze” as a new Medicaid provider:

Medicaid is one of those things where I’m sure there’s a lot of instructions on how to do it, but it was never really just laid out very easily. It’s not in a one-page document. It’s like, in a 5000 page document and there’s little pieces of it here, little pieces of it there... they give you the manual, and they’re like, “Well, here you go. As a provider, here’s your manual ... good luck!

Other participants shared this feeling of being overwhelmed and left to figure things out on their own when they first started working with Medicaid. The extensive manuals were intimidating and Dr. Martinez, a local psychologist, said it took more than three months to get through all the paperwork before she could become a provider. Kathy, who worked for a local ophthalmologist as an office manager, had over eleven years of experience working with Medicaid. She still remembered the frustration of learning by trial and error in submitting claims to Medicaid and said she “felt sorry” for new Medicaid providers that “had never done anything with Medicaid before.”

Some healthcare workers were upset about the kind of interactions they had with Medicaid support staff. It was hard for Medicaid providers to get answers because most of the time they couldn’t trust that they were getting accurate information. Kathy’s impression of Medicaid’s phone staff was that “these people are just people off the street that have no training whatsoever...they basically take what they’re telling you out of some scripted something that they really don’t understand.” Dr. Allan, a local dentist,

said that Medicaid personnel “have really odd things that they tell you, and you can just tell that they don’t really know. They just don’t know anything that they’re really talking about.” Henry, a program director for a mental retardation organization, said they were often “short” with him, would give him “limited information,” and they had a “monotone” personality “not, ‘oh, how can I help you?’” Dr. Martinez described them as “flippant” and “rude” even when they didn’t know the answers themselves.

Just being able to get connected with someone to talk with was a challenge in its own right for many Medicaid providers. Amanda, a self-employed private therapist/counselor, talked about her experience saying “it’s a lot of being on hold a long time. That’s not fun.” Dr. Matthews, a local optometrist, said being on hold for so long just to talk to someone was one of the things that bothered him most about working with Medicaid. Not being able to get responses through official channels in a timely manner can place additional burdens on small business owners who must either sacrifice time that could be spent servicing patients or “wing it” by trying to make sense of confusing claim procedures. As a small business owner, Amanda said “that’s hard, because I don’t have anybody to delegate it to...I have to do it between appointments... if I’m on hold too long, I just have to hang up and start over. It’s pretty discouraging.”

Visiting the Medicaid office can also pose a challenge for providers who must represent clients who are unable to fill out forms for themselves. At these times, providers face many of the same frustrations as Medicaid applicants. Kanisha, working as a client services coordinator for a large clinic servicing clients with mental retardation, explains:

You get there, and people are on the phone, and you've got to pull a number. There's a bunch of people in the waitroom. It feels like nobody really cares about what you need, about helping you. And then when you get help, it's attitudes and things like that. And then, a lot of people, it seems like don't want to help our clients. It's just a bad vibe, I guess, that you get when you go in there.

Healthcare workers didn't think Medicaid personnel really cared about helping them in their work. For example, Frank, a mental health caseworker, often had to go to the Medicaid office to represent one of his clients. He said his first experience going to the Medicaid office was "kind of an eye-opener" and gave him "a weird vibe." The office itself was "dirty" and when Frank realized he "was going to have to wait forever just to get the applications" for his client he decided to leave rather than wait. Henry said he experienced the same reception at the Medicaid office having to endure long waits and expressions of indifference even after Medicaid personnel at the main office knew he was a program manager representing patients.

When accepted as a Texas Medicaid Provider, healthcare providers are assigned official area representatives who field specific questions about policies and protocols. At least this is how it is supposed to work. Unfortunately, providers said they rarely heard from their representatives and it was hard to reach them. Dr. Martinez was a new provider and felt the Medicaid representatives "don't have time for us. They aren't very pleasant either. She's always, like, real busy... I don't have anybody that I feel like I

can say, 'I don't understand how to do this, can you teach me?'" Dr. Allan had a similar experience in his dental practice:

We have a rep that's locally in this area, and we can call her up, but usually when you call her up, it's like, you're not going to hear back from her until at least two or three days later...but usually then, she doesn't have the answer. Then she has to go ask somebody else, and then it will probably be at least a month before we hear back from her.

Other technicalities made it difficult for providers to find answers to their questions, further reinforcing the perception of Medicaid as unreliable. Dr. Martinez pointed to a problem with Medicaid's website where she was supposed to download the fee schedule for coding services. When she went to the website she couldn't find a fee schedule set aside for psychologists:

Even my fee schedule doesn't say "psychologist," so when you go down the list of fee schedules, you have to keep opening up different ones. And now I know which one it is, because I've done that, but I had to go and open up each one until one popped up and it said something about physicians, something else, psychologist, something like that, but it's not on the front list. It only says "physician."

Healthcare providers thought Medicaid personnel were apathetic toward their needs – especially financial needs. Providers not only couldn't get help from Medicaid personnel to get questions answered or to find important resources, some felt thwarted in efforts to collect payments for the work they performed. Wendy, who works as an office

manager for Dr. Allan, shared several experiences about times they had been unable to get reimbursed for substantial service claims. On one particularly expensive claim, she recalled being unable to get a return call after considerable follow up effort:

We have talked to our local provider rep. We've talked to several head people at Medicaid. Dr. Allan has talked to them, and it's still ... I mean, it's now over a year old and we just wrote it off... They said they would work on it. I sent them everything – the EOBs, the claim that we originally sent in, the Medicaid card showing that they had coverage during that time – and it's like, everyone just quits calling you. You call them, and they quit calling you back....so now, we've just had to [write it off]... I mean, that was literally over \$2000.

Dr. Allan said this difficulty in getting paid wasn't isolated to his business, but was echoed by other dentists in the area who used this as a reason for not working with Medicaid. If things weren't right, the fault and responsibility was with the healthcare providers – not Medicaid personnel or policies. When something didn't make sense, it was hard to get clear answers.

Brenda, a nursing director for a large mental health facility, said Medicaid representatives would periodically call to quiz her on how she was interpreting various billing codes. If her understanding of the billing codes contradicted how the representative saw them, she was told she was doing it wrong. Brenda argued that “the codes are real interpretive...but she [the Medicaid representative] doesn't understand what nursing does that much, and so she interprets them the way she sees, so we're limited to what codes we can use, which have very little reimbursement.” But the hard

part was “there’s no argument with them. When they say you’ve been doing this wrong, you’ve been doing it wrong.” When asked if they could petition a particular interpretation of a code they disagreed with, the answer was a simple no. In this situation, the Medicaid representative held most, if not all, the cards. Medicaid staff members were adversarial, often leaving the provider with few options:

Usually when we find a way, when we find a source with Medicaid that’s really reimbursing, then they [Medicaid personnel] will change their reimbursement. If they find somebody, that people throughout the state are really getting a lot of money from this, then they’ll change the game plan where they don’t have to pay that much money any more.

Workers seemed sincere in their interest to learn, but official resources were limited or unavailable.

Better Than or Equal To

Some healthcare workers thought Medicaid was better than what it used to be like before they could submit everything electronically. Other providers thought it was better than or at least equal to other insurance companies with whom they worked.

Some owners and office workers remembered what it used to be like working with Medicaid before things went to the online clearinghouse. Diane, a dental office manager, said she had:

worked at a practice where we accepted Medicaid, and it would take six or seven months to get payment in. Always had a hassle. Always denying the claims...It was just crazy. Everything you basically submitted was denied, and you had to

resubmit all this different paperwork... Now, once you've registered to be a provider for Medicaid and all that paperwork and everything is done, we're actually set up through the Internet. We submit everything electronically.

There's really no ... it's not a lot of paperwork or anything, and turnaround for payment is a week. You do treatment on a Monday, and the next Thursday you have a payment in your account.

Diane's description of Medicaid as it used to be offers a dramatic contrast to the current system where there's "not a lot of paperwork or anything" and payment comes in just over a week. Charla, a self-employed therapist/counselor, agreed, saying that "Medicaid has one of the best insurances as far as the amount of time...It's a ten day process from when you file to when you get paid." Other insurance companies could take up to "90 days" and by then "you've forgotten who the person was or that you made the claim, and that's insane." Amanda, another private counselor/therapist, said Medicaid was "a steady thing" that helped her small business since she would "usually get an electronic deposit every week."

Dr. Martinez is also a self-employed psychologist and agreed that faster payments were one of the clear benefits of working with Medicaid. Medicaid payments were at least "comparable...usually the other [insurance] companies are a little less." According to Dr. David, a dentist, "once you do your work and then you submit it to Medicaid, you get your reimbursement within two weeks" which makes Medicaid "very fast...as long as you do it online." In his opinion, Medicaid "runs smoother than some of the insurances that I deal with...with other insurances...it's more of a nuisance."

Working with the current Medicaid system also simplified some of the office work that was necessary for healthcare providers. Julie, an optometry office manager, didn't ever remember losing money with the old Medicaid, but said that codes were often "put in [by Medicaid personnel] incorrectly and so it got denied. It was correct on our form, but anytime you had somebody else interpreting what's on your form, you have the opportunity for that." She thought the new system of Medicaid was better than the old because she and her staff now have control over how the service codes are entered. Eliminating the middle person from the equation reduced the potential for mistakes and made Medicaid more appealing.

When working with other insurance companies, providers have to deal with collecting co-pays or deductibles. For some offices this might not be a big issue. However, for a small self-employed operation:

I'm really at a handicap...I was just talking with a friend of mine yesterday, and what she's running into is they'll say, "Well, we don't have the co-pay today. We'll pay you next time" and then they don't show up for other visits, and so it's hard to get the co-pay from them. (Dr. Martinez)

Diane thought it was easier to submit claims with Medicaid than with other insurance companies because "most insurance, you have to send x-rays for crowns and root canals... [but with Medicaid] You don't have to send x-rays... I mean, it's no paperwork involved at all."

It can also be difficult if a client has to first meet a deductible to qualify for services because "clients will tell you they have [met their deductible] when they haven't." Dr.

Martinez preferred Medicaid because everything can be done by dealing directly with the company – if clients have their Medicaid card they are qualified for services and there's no need to collect money from the patient.

Amanda thought working with other insurance companies can get “complicated” for small businesses because:

I have to deal with a family that has a high deductible, and then I have to deal with co-pays and collections. If they have more than one insurance, I have to send to one insurance company and then after that either gets paid or denied, then it goes to the secondary insurance company, and it may take me multiple months to get paid.

Dr. David encountered difficulties when “people come in with insurance and some of the insurance won't cover some procedures that we provide...that's more of a headache for us because we have to argue with insurance, where right now, we don't have to really argue with Medicaid.” He liked working with Medicaid because they trusted him “to make the right decision to provide for these patients which is kind of a relief for us because we don't have to worry about, if I do this procedure, are they going to pay us?”

Individual and Professional Values of Indigent Care

Medicaid policies and practices form a challenging constraint that shapes the way workers experience their work environment, but these professionals also face other constraints that further shape what they experience. The second part of the first research question asked: *How do healthcare service workers make sense of a complex work environment where they are constrained by (b) national, professional, and individual*

values associated with indigent care? I will now discuss the individual and professional values healthcare workers associated with indigent healthcare; these values represent the second major constraint Texas Medicaid providers faced. Based on my interviews, healthcare workers closely identified individually and professionally with indigent healthcare but clashed with the Medicaid program.

Identifying with Indigent Healthcare

Healthcare workers unanimously identified with providing services to indigent groups. They talked about indigent healthcare as a satisfying way to make a difference in someone's life and as a duty worth the sacrifice of money and comfort.

Healthcare workers felt that working with indigent groups was a satisfying way to make a difference in someone's life. Alicia, an admissions worker at a non-profit community pediatric center, said she was working there because it brought her "satisfaction to be able to know that I've helped someone who was in need, because they didn't have the medical coverage needed for them to be able to see a doctor." Kenesha's job as a mental health caseworker put her in contact with families who cared for a mentally retarded child or sibling. In spite of the challenges she faced in working through Medicaid rules and policies, she said her job was "good because you feel like you're actually helping...this is like an extra boost for them." One pediatrician, Dr. Timothy, said he was glad he had landed his first job working for a lower-income pediatric clinic because it meant he would be "doing just a little bit more than just my part." Even though he talked about friends who opened their own practices after school

and made more money than he did, in his mind doing “just a little bit more” brought greater satisfaction than he could get by having his own private practice.

Marlene, a dental assistant, highlighted how helping anyone who did not have the financial means to get healthcare made her happy – not just people who were on Medicaid. This dental office provided indigent healthcare “to the community, because it’s not just Medicaid we see. We see other people that don’t make a lot.” Similarly, Dr. Allan, a dentist, mentioned that even though many of his peers would refuse to work with Medicaid, they would still find some way to take care of people who needed their help even if it meant not getting paid at all for their services. According to Dr. Allan, this was a common practice within the dental community – their commitment to helping those that did not have financial means was independent of Medicaid.

For many healthcare workers the desire to help extended well beyond those on Medicaid. Dr. Rasmussen, an ophthalmologist who had been working with Medicaid for more than 30 years, saw “a fair number” of patients “that are either not quite poor enough to be on Medicaid, or they’re a non-citizen and not able to get on Medicaid.” His interest in non-citizens and others that cannot qualify for Medicaid services seemed equal to, if not greater than, those who were on Medicaid because “these people are doing something within our economic system. They might be washing dishes or welding trailers together or something like that, but they’re part of the process.” As “part of the process” he felt they deserved access to adequate healthcare. Similarly, many of the patients Alicia admitted to their community clinic were “undocumented children that come from other countries and they don’t have any way to apply for

Medicaid or anything like that.” Part of what gave her so much satisfaction in her job was that these undocumented patients could still be put on the clinic’s “sliding fee scale program and if they bring all the documentation needed, we’re even able to give them their office visits for free.” It was difficult to conduct a single interview with a healthcare worker without hearing about the satisfaction they felt in helping people that needed their help – especially those that could not qualify for the Medicaid program.

Not only did healthcare workers *want* to help people who couldn’t afford healthcare, they also felt it was their *duty* to help them. Dr. Rasmussen said working with Medicaid was more of a “public service” he performed for the community as he couldn’t even cover his overhead from the work he did with Medicaid patients. Debbie, a pediatric caseworker, framed her job at the local community clinic as a “calling” – something more than just a desire. In her mind, her job was all about “saving a life”:

It’s the people, you know? That’s what I’m here for, to make sure that they get the care that they need...It doesn’t matter if they are a Medicaid recipient or not.

The thing is, that patient is what’s important. That life is what’s important. You know, saving a life, and so that’s what’s really important.

Similarly, Janelle’s duty as an optics worker was “to get the people to see. That’s the most important thing...and that’s why I do it. I don’t know if anybody else does it, but I do.” She said she was impressed with the doctors that worked in her office because they exemplified these values. As a practice, they were thinking of ending their work with Medicaid because they were losing money, but once the recession started, all talk of stopping Medicaid came to an end. Their duty was to help those in need of vision care.

Janelle went on to describe how the owner would upgrade a child's lenses to a higher quality material if the prescription was unusually strong without charging if they were paying with Medicaid just so the child could have a lighter pair of glasses.

Mental health providers were similarly adamant about fulfilling their duty to the indigent clients they served even if it meant they would have to suffer financial losses for that service. For example, Dr. Martinez admitted that in order to keep her patients coming to therapy she had to significantly reduce her rates as a licensed psychologist:

My sessions are about \$30 less than the going rate because I deal with a poor population...we [psychologists] shouldn't do that because we undermine each other, but at the same time, I need my clients to come consistently, and so if I have it too high, they'll only come sporadically and we won't get anything done. So I keep them at a sort of reasonable rate for them to be able to pay...I deal with very, very poor people.

Stress was part of working with Medicaid patients. Julie reminded me that kids on Medicaid often had "big families" and weren't always the most well behaved, so working with Medicaid patients could get challenging in their office. Dr. Matthews, an optometrist with a private practice, admitted that working with Medicaid patients was frustrating sometimes but "you have to put up with a little bit of the frustrating stuff to make sure that you're doing what you're supposed to be doing [helping indigent groups]." Even Wendy, an experienced office manager, admitted she often over-extended herself "because I feel for them. Sometimes I think I let myself get too wrapped up." She saw herself as a "caring person" and for this reason she was "going to

help them” if she could. After all, she “would want someone to do that for” her and therefore felt duty-bound to sacrifice time and comfort in helping others to have what they needed.

As a self-employed therapist, Amanda recognized that “there’s a lot of poverty in this county, and a lot of people don’t want to see it, but it’s there...this is a really rough time and I expect with that, there’s going to be more need for mental health intervention.” She told me that for her, it wasn’t “about the money.” What really mattered to her was to “be involved and to try and help in some way.” Even though she wouldn’t get paid much, she was committed to doing what she could within her field to help those in need. She later suggested with a wink that she’d have to keep taking her pottery class to deal with the stress of being a Medicaid provider.

Clashing with Medicaid

Healthcare workers unanimously supported the values associated with indigent healthcare (e.g., helping the poor, focusing on helping others rather than making money), but some clashed with the Medicaid program. They framed Medicaid as one possible way to provide healthcare to the poor – not the *only* way. For example, Dr. Allan mentioned that other dentists in the area who refused to work with Medicaid still found ways to help indigent families by doing work pro bono. Similarly, Dr. Martinez talked about lowering her therapy rates so patients could afford to commit to ongoing treatment. She told me Medicaid was something she was “forced” into because she wanted to work more with kids in Child Protective Services (CPS) and they paid providers via Medicaid. To do what she wanted to she had to work with Medicaid.

Three themes emerged from the data that explained why providers clashed with Medicaid: 1) Public perceptions of Medicaid patients created a negative public image for their organization, 2) Medicaid unfairly excluded deserving poor families from government aid, and 3) Medicaid gave help to people that abused the program.

Medicaid gives providers a negative public image. Healthcare workers were concerned that Medicaid's negative public image would rub off on their own businesses. This guilt by association was something that often held providers back from working with Medicaid. According to Dr. Allan:

That's one huge thing why some dentists won't take Medicaid...the image it creates. I think they [other dentists] have good intentions about doing it, and they're definitely I think capable of doing that stuff [taking Medicaid], but socially they don't know how to integrate that into their office, because they know that it's going to harm their practice overall.

It was this "social" aspect that providers had the hardest time dealing with. Dr. David labeled the social problems that came from dealing with Medicaid patients as a "total lack of respect." His problems with Medicaid's public image came to a head when he started asking other dentists about it. As a young dentist he was deciding whether or not to work with Medicaid patients and was warned against it. He "heard of stories [from other dentists] like kids peeing in the waiting room... I was told never to mix your Medicaid with your normal patients." Diane, his dental office manager, was convinced that a lot of dentists "just hear the word 'Medicaid' and they think 'slum,' 'trashy,' and

they don't want to have that image in their practice... it takes away something from their office.”

Healthcare workers talked about the tangible consequences that came from having too many Medicaid patients. Having lower-paying patients means you need more of them to pay for the same kinds of service. This translates into crowded waiting rooms, lower-paid professionals and staff members, and the possibility of service problems. Dr. Rasmussen, an ophthalmologist, said working with Medicaid patients could be “risky”:

It's a little bit of a risky thing to do...the more Medicaid patients you have sitting in your waiting room, there's probably a little bit less likelihood of bank presidents wanting to sit in there with them...the higher end of your more economically successful people will choose to go sit in a waiting room where there's not Medicaid patients. Then that increases your Medicaid percentage. So there can be, I suspect, sort of a spiral downward from that.

Because healthcare practices need higher-income patients to balance out low Medicaid reimbursements, maintaining a positive public image was important. Staying above water required a balance of private and public paying customers and an eye towards reducing the negative footprint Medicaid left behind. Dr. Allan learned from his own experience that “Medicaid definitely brings a lot of baggage...If you don't know how to control it properly, then it can wreak havoc on you.”

Medicaid excludes needy families from government aid. Healthcare workers blamed the Medicaid program for giving government aid to the wrong people. Tiffany,

a dental assistant disagreed with how the Medicaid program determined who should get services as “a lot of families...don’t qualify, who honestly are doing what they can for their kids, and they’re trying to find the insurance and they’re trying to get their kids in, but they don’t qualify.” She identified with the values of indigent healthcare but clashed with the values that guided Medicaid’s qualification standards. Helen, a financial manager for a large non-profit mental health organization, expressed similar concerns. She was glad Medicaid was there to help people but hoped that “the ones that really need it are getting it” because it was common to “see clients that may not be making any money at all...but they can’t get Medicaid.” Like Tiffany, Helen thought “there’s something wrong there.”

Kenesha, a caseworker, noticed that Medicaid personnel often rejected applications for aid from families with mentally retarded children “because of something small...like a technicality.” Such ‘technicalities’ included such things as the wrong start and end date of a previous job or a missing signature. Often, mistakes would happen when the client being treated was an adult and filled out their own application. Because they often couldn’t remember facts dealing with work history, etc. very clearly, they would often include erroneous information. Kenesha thought they should be given a little extra flexibility because of their mental condition and explained that these families were doing all they could to cover expenses and shouldn’t have coverage completely denied over a technicality that could be corrected and resubmitted. Having to start completely over because of a technicality meant that it would take even longer to get necessary financial aid to families that were doing all they could but couldn’t make it on

their own without extra help from government funds. However, healthcare workers were not only upset that some people were not able to get government assistance, it bothered them that there were people on Medicaid that didn't seem to deserve what they were getting.

Medicaid provides services to people that abuse the program. When asked what it was like to work with Medicaid, healthcare professionals shared examples of Medicaid patients who were financially fit. For example, Lisa, head of optics, was upset with “the person that comes in, on their cell phone, with their Bluetooth, carrying this designer purse, and then they’re not going to pay anything for their glasses.” Seeing this “gives you that whole feeling, well, why are you on Medicaid?” It was hard for her to sort out the justice of someone not having to pay for their healthcare and still being able to “afford a cell phone, and... pay all these bills.” In her opinion, if “they’re sitting there, and they’re talking on their cell phone about all these things they’re doing or places they’re going” they could use that money to pay for their own health expenses instead.

It bothered workers to see patients qualified for Medicaid services who appeared to be financially capable of paying for their own medical expenses. Tiffany, a dental assistant, tried not to assume that every person that walked in with a “60 dollar pair of shoes” was trying to cheat the system because “it might be gifts from families, for all I know.” However, she wasn’t blind either. She recognized that “there are those people that do it, taking advantage of WIC, taking advantage of all the government things” and that those actions had real consequences because “that takes it [money] from us, because

Medicaid and stuff, that comes out of our pay, so that takes it out of us, and people take advantage of it.”

Other healthcare workers agreed that there was something wrong with a program that qualified the wrong kind of people for indigent healthcare but excluded those that seemed to be doing all they could to make ends meet and still needed help. Kathy, an ophthalmology office manager, said one woman with several children on Medicaid “invited us to come to the parking lot to see her new Cadillac.” To Kathy, there was “something wrong with that picture.” Lisa mentioned that she wasn’t able to afford a lot of the things some of her Medicaid patients came in with because she was trying to act responsibly and “save” for the things she needed. If patients could afford to be “coming in a Hummer” said Maria, a front desk worker and dental assistant, they should be able to afford to pay for their own healthcare: “I mean, I have a job, and I’m not driving an Escalade.”

What was particularly galling for many workers was that Medicaid patients not only had financial resources but even *bragged about* their prosperous circumstances. Megan was a front desk worker at a dental clinic and was upset at what she saw because:

It’s like they don’t try to hide it. We have one that comes in... with a company truck, and has their name on it, ‘So and So Construction.’ They drive the nicest vehicles...I’ve been [working] at Wal-Mart for a while, just part-time. So I know some of them, their spending habits, where [their money] is going. And then I’m thinking ... I don’t know...how are you qualifying for this?

Megan held the Medicaid program responsible for qualifying people that really didn't need the help for services. Workers were not merely at odds with the patients, but were upset with the indifference Medicaid showed towards this abuse. For example, Lisa thought the program was "letting them [Medicaid patients] get away with too much."

Janelle, an optics worker, was upset that people could spend their own money for stylish frames and then use Medicaid to cover the cost of lenses:

And sometimes ... get this! Okay, say we have our selection, okay? And if they don't like what they see, they can pay \$100 for a frame. And then, the only thing that we can claim is the exam and the lenses. Now, to me personally, if you can buy that frame, then I would think that that would knock them out of the program.

Dr. Timothy, a pediatrician, said it was hard to work with Medicaid when patients didn't demonstrate a willingness to do their part to cover medical expenses. For example, it was common for parents and/or patients to use Medicaid to cover an over-the-counter medication they should have been able to cover on their own:

Sometimes the parents will come in because they're out of Tylenol and they know that Medicaid will pay for Tylenol, so they come in and they need a prescription for Tylenol. But if they had paid \$5 for the visit, well, then [they should] use that \$5 and they'd go get their \$2 bottle of Tylenol, as opposed to taking the doctor's time for an unnecessary visit.

Thus, these interviews demonstrate that healthcare workers agreed with the values embedded within indigent healthcare but often clashed with the values that emerged

from their interactions with Medicaid policies and patients. Healthcare workers had a negative impression of the Medicaid system because of the negative public image the program carried. They also clashed with Medicaid values that prevented more deserving families from receiving government aid. Last, they clashed with Medicaid values because many of the patients who did meet qualification standards seemed financially stable and fully capable of paying for their own medical needs.

Rules and Policies of Different Organizational Forms

Being in the middle also meant that healthcare workers had to deal with the natural strengths and limitations of the organizations within which they worked. The third part of the first research question asked: *How do healthcare service workers make sense of a complex work environment where they are constrained by (c) rules and policies associated with specific organizational forms?* Workers made sense of organizational rules and policies related to Medicaid based on the type of organization they worked within (private or non-profit) and the type of healthcare service they provided to patients (i.e., dental, mental health, etc.)

Perceptions of Work Rules and Policies: Organization Type

The healthcare workers I interviewed belonged either to traditional private practices (with revenue from cash, private insurance, and Medicaid patients), or public/non-profit clinics specifically targeting indigent groups (with revenue from county appropriations, cash patients, and Medicaid patients). It was clear that individuals in these two practice types looked at their work with Medicaid differently. Private practice employees described their Medicaid-related rules and policies within

their organization using a loss-driven approach. Public non-profit workers talked about their rules and policies using an income-driven approach.

Private practices: a 'loss-driven' approach. Private practice workers talked about the financial losses Medicaid generated for their businesses. They wanted to be Medicaid providers because they believed in helping the poor but they needed to make a profit to stay in business. For this reason, each practice established internal rules and policies to limit the negative impact Medicaid could have on their bottom line.

Some practices found ways to reduce the impact of having too many Medicaid patients by restricting who they were willing to treat. For example, after a local dental practice in his area suddenly closed, Dr. Allan's office was "bombarded" with a surplus of Medicaid patients looking for treatment. Dr. Allan was concerned and talked with his Medicaid area representative:

I told her about it, and I was like, well... I can't see this many people. Every call that we get is from Medicaid, and we can't do that because I can't just have a fully Medicaid practice. It doesn't make business sense to do stuff like that.

At first Dr. Allan thought he would need to stop working with Medicaid patients altogether, but by treating kids on Medicaid between the ages of 1 and 4 he was able to reduce the number of Medicaid patients that came to his office enough to continue as a Medicaid provider.

Other practices reduced the impact of their Medicaid clientele through scheduling policies. For example, in order to reduce the impact of "no shows" which were much higher with Medicaid patients, Julie said they actively worked to spread the

number of Medicaid patients they saw throughout the week. This way, she reasoned, they would be able to avoid losing half a day's earnings when Medicaid patients inevitably didn't show for their appointments. It also allowed them to spread out the reduced payments that came from Medicaid for services throughout the week. Dr. Matthews had a similar idea by making it an office policy to not schedule large families all on one day. He would take up to three people from the same family on a single day, but any more than that and they would have to be scheduled for a separate visit. In his experience, Medicaid no shows had "happened too many times to ignore" and he felt this would adequately reduce his losses.

Another way private practices reduced Medicaid losses was through preventive policies and sanctions. Preventive policies usually involved making an effort to call patients in advance to remind them of appointments. Diane, Dr. David's office manager, said that it wasn't uncommon for them to call three times to remind a patient about an appointment. Other practices often called at least twice before an appointment. Similarly, to avoid wasted time, if a Medicaid patient at Dr. Matthews' office didn't have appropriate information it was standard practice to reschedule the appointment. Dr. Martinez said that while it took extra effort, it was worth her time to call into Medicaid or go online and check to make sure a Medicaid patient's account was active rather than take the risk of not getting paid for a visit.

Private practices also used sanctions to discourage Medicaid patients from missing appointments. Charla said that if patients missed two appointments in a row for therapy, she wouldn't allow them back. Similarly, in Dr. David's office, there was a

“three strikes and you’re out” policy to discipline people that repeatedly missed appointments. Once out, they were not allowed to get services at that office. With so few dental offices willing to work with Medicaid, this became a viable threat to prevent financial loss from missed appointments. Most, if not all, the private practices I interviewed had some form of policy sanction that was designed to discourage “no shows.”

Public non-profit organizations: an ‘income-driven’ approach. All the public non-profit workers I spoke with said their clinics depended on Medicaid as the primary source of income to support their work. For these organizations, rather than a liability, Medicaid funding was crucial to financial stability. It was in their best interest to get as many of their patients on Medicaid as they could. For this reason, signing patients up for Medicaid was built into the rules and policies of these organizations. Each of the public non-profit organizations I interviewed had access to an in-house Department of Health and Human Services (DHHS) Medicaid worker or had created a position whose primary responsibility was to be a Medicaid policy resource for organization members.

Medicaid was vital to the financial success of the public non-profit organizations I interviewed. Dr. Timothy mentioned that because their pediatric clinic is part of a FQHC, the federal government reimbursed his organization for Medicaid patients at a higher rate than his service costs. Their organization would accept most forms of payment, including Medicaid, cash (using a sliding scale based on income to determine cost), and nearly any form of health insurance. However, their main forms of payment were Medicaid and sliding-scale cash payments. Getting greater than cost

reimbursement for their Medicaid services was one of the reasons they were able to offer a sliding scale cash option. For example, while a particular visit might cost the organization \$40 including wages, overhead, and supplies, Dr. Timothy could accept a \$20 payment from someone using the sliding scale cash payment option because he was paid \$60 from another patient who paid with Medicaid. Medicaid allowed the services at the clinic to balance out and made it easier to provide services to cash-paying patients in a way that each patient could afford. According to Dr. Timothy:

As long as my Medicaid patient base is around 70% or so, and the cash pay is at 30%, it balances out. But if my number of Medicaid patients start shrinking, that means my cost or my loss on cash paid patients will go up, and now I'm getting closer to not making ends meet.

Unfortunately, there is a "huge demand" from cash-paying patients and "a lot more adults want to come here than we can see." This makes it a challenging situation for Dr. Timothy and the rest of his clinic because they want to help the adults that pay cash but are naturally "hesitant to increase that capacity because we're going to be increasing our losses as we provide care to the cash pay adults." In order to manage this process, they have instituted a bottle-neck to slow down the number of cash-paying patients so that Medicaid patients will always exceed the number of cash-paying patients. In order to make this work:

The bottleneck is that they can only see so many adults per day per time. We have a rule that the adults, an adult patient has to come in and be seen for a physical before they can get seen for anything else. That way people don't drop

in and out just as needed. We've created some artificial bottlenecks to keep that balance, that ratio.

An additional way this office has been able to increase the number of Medicaid patients coming through their doors is to have patients see case workers before an appointment with a physician. During that visit, the case worker discusses the family's Medicaid eligibility. If children qualify for Medicaid services, but are not currently on Medicaid, the case worker helps them fill out all the paperwork to apply for the program. The office also has an in-house Medicaid worker to streamline the Medicaid admissions process and help families and caseworkers solve any unforeseen problems. According to Debbie, one of the caseworkers:

We have a DHS caseworker here that's stationed here in our clinic, and we can ask whatever information that we may need... Maybe there's just something that a little piece of paper that missed, that they don't have all the documentations. You know, a lot of times, there could be a lack of communication that they forgot, or want the picture ID or social security card... That way, the problem can go ahead and get solved and the patient can go ahead and get the care that they need.

Perceptions of Work Rules and Policies: Healthcare Service Type

Not only were healthcare workers faced with challenges based on whether they were a private or public non-profit organization, they also had unique strengths and limitations placed upon them based on the type of healthcare service they provided.

Dentistry. An obvious challenge facing the dental practices was trying to find ways to deal with the enormous need among Medicaid patients for dental services. Dr. Allan remarked on this during our interview, noting the strong “need in this area” for dental services. Even after instituting client age restrictions, nearly 30% of his business still came from Medicaid work. According to Tiffany, a dental assistant at one of the local clinics, “on a good day for one doctor, we’ll probably see at least 20 to 24 patients. There’s days that we have more than that.” She mentioned that all their patients are double-booked between 8am and 5pm and that they often stay past 5pm because they also triage between one and four emergency patients each day. While appointments are often fairly short – 30 minutes to an hour – coping with the number of people that need to be seen is a real challenge.

Dentists commonly talked about using informal networks to reduce the patient load and share the burden. For example, Dr. David mentioned that because Dr. Allan “only sees up to, like, 4 years of age. I’ll try to see them, but if they’re a little too apprehensive, then we try to refer him some of the kids that are younger.” Similarly, Dr. Allan mentioned that it was common practice for him to refer older kids to Dr. David. In addition, because of Dr. Allan’s specialty in oral surgery, Dr. David would often refer patients to him that “have severe decay, that have cavities throughout the mouth” and would benefit from sedation. By referring patients to one another they were both able to reduce the overall patient load that came through their doors to a manageable level. Tiffany and Maria both mentioned that it was standard practice for them to refer patients to a private practice dentist if they wouldn’t hold still during an office visit from being

too wiggly or because they were scared and couldn't calm down. Private practices could sedate kids better and spend more time with them than they were able to do at their non-profit clinic.

Dr. Allan suggested how relying on other care providers was also a challenge. For example, because Dr. Allan did a lot of oral surgery in order to make multiple cavity fillings possible for younger children, he relied on anesthesiologists who billed separately for their services. These professionals may not have as many incentives to work with Medicaid as Dr. Allan did because “on the anesthesia side, it’s [the Medicaid reimbursement] very low.” Dr. Allan noted that dentists had discontinued Medicaid patients because of this problem. Thankfully, the professionals he worked with were willing to do whatever needed to be done, even doing “stuff for free” if necessary to make sure kids had the care they needed.

Another problem facing dentists is being able to get paid for a service that another dentist has already provided for a patient. Wendy, Dr. Allan’s office manager, noted that Medicaid has recently decided that “if there’s x-rays involved, and they had them over there [at another practice], we can’t take them. If we take them here, they won’t pay for them.” Dentists generally like to take their own x-rays to ensure they have found what they are looking for – which makes it tough to swallow when Medicaid refuses to cover these procedures. Ultimately, after trying to hash it out with Medicaid over the phone, Wendy said they just “write them off” and take the loss.

Optometry, ophthalmology, and optics. Optometrists also faced the problem of having people come into their offices who had already been seen by another optometrist.

If a patient goes to an optometrist for a visit after receiving another eye prescription during the same month, the second optometrist will not get paid. As a result, it has become common practice for optometry offices to check with Medicaid prior to scheduling an appointment to ensure they will get paid for the visit. Because the authorization process takes some time, optometrists are not thrilled about having to do this. To reduce the amount of work for other practices, Dr. Matthews has begun writing their “names and the date in the area that’s checked for the eye exam” after seeing a patient. His hope is that other practices will notice this when they see a Medicaid patient’s card and begin doing the same thing so that they all can benefit from skipping past the authorization process.

Unlike dental services, Medicaid actually seemed to pay pretty close to what other insurance companies paid for optometry services. Dr. Matthews mentioned that:

If it’s a child who we’ve never seen, we get reimbursed about \$45 and some change, which for standard insurance, it will range from about \$40 to \$50 for reimbursement, so it’s really pretty much right in the middle for the standard vision coverage.

In addition, while there is a “pretty big patient base” with Medicaid, Dr. Matthews said that only two to five percent of his patients used Medicaid. This is a dramatic difference from the dental community where it was common to have between twenty and thirty percent of the patient base using Medicaid. Kathy, office manager for Dr. Rasmussen, mentioned that their patient load was close to 15% from Medicaid but that they “see probably more than the average practice does” in the area. The optometrists I talked

with didn't see too many problems with how Medicaid works for them in their businesses. However, it is important to point out the difference between optometry (which deals with getting a vision prescription) and optics (which deals with getting the lenses and frames). All of the practices I spoke with had a prescriptive component to their practices. However, only one had an associated optics program built in and it was in discussing the optics side of vision care that I heard the most concerns about Medicaid.

On the optics side, Medicaid pays far less than other insurance companies or cash-paying patients. Janelle, an optics worker, told me that "it's like, \$14 or \$15 for a frame, that we get paid." When the frames cost \$50 each, they are already taking quite a financial hit just by being willing to accept Medicaid. However, the real cost comes because of a rule that applies to glasses paid for by Medicaid. If a child breaks or loses their glasses, Medicaid will cover the cost of getting new glasses. This means that Medicaid providers are obligated to replace glasses for kids who need them. Normally this would be a commendable policy because kids have a strong tendency to break or lose glasses. As Lisa notes:

You have those kids that have such a strong prescription that they can't see, and if they had to buy a new one, their parents wouldn't buy a new one. And so that's when it's really good.

The difficulty arises with "the kids that come in and you've seen them six times in the last eight weeks with broken glasses." Sometimes they are just being too careless with their glasses, but the staff workers I talked with were convinced from their experience

with these kids that it's more often because they don't like the frames their parents picked out for them and they want to choose a different style of frame.

Regardless of why they are broken, Medicaid policies dictate that optics centers have to replace the glasses. All of the staff agreed that the costs in time, effort, professional frustration, and money add to the reasons why this rule, when abused, can become a difficult burden on optics personnel. According to Janelle, "we're not paid for our time of repairing...I do a lot of the repairs and stuff back there in the lab. We don't get paid for that. It's just a service." In addition, she told me that Medicaid prescriptions are often strong which means additional work crafting the appropriate lens.

Based on what participants said, the problem with this policy is two-fold. First, it does not account for all the costs in time and equipment necessary to provide limitless replacements to patients. Second, there are no incentives built into the policy to encourage parents and kids to avoid losing or breaking their glasses. While they can't change the Medicaid policy, the workers I talked with have actually started charging their own \$18 re-order fee on broken glasses in order to give some incentive to parents and patients to prevent this from happening. To deal with their rising frustrations, some of their other coping techniques include the use of humor such as playing "rock, paper, scissors" to see who is going to handle patients that frequently come in for replacement glasses, asking direct questions about how the glasses were lost or broken so that the patient feels a sense of responsibility for the loss, and tag-teaming each other to handle difficult patients when they have reached their limit of frustration.

Mental health. Mental health workers also face unexpected challenges because of the type of work they do. One of the biggest challenges for new mental health professionals is finding a billing category that accurately describes and pays for services provided. Dr. Martinez mentioned that one of her greatest frustrations was the differences between how Medicaid allows her to bill for her work compared with how general doctors are allowed to bill:

A medical doctor, I think they can have 25 an hour, or 5 an hour, I don't remember, but they have a large amount of clients that they can see per hour, and bill more per hour than what we can bill. We, as psychologists, have to bill 45 or 50 minute increments, and medical doctors do not. And so, that also, I think is really unfair. Or maybe, I think they are limited to 25 billed clients a day or something, and we're limited to 8.

Dentists and optometrists are allowed to bill according to procedure, making it much easier to get paid for their work. Not knowing exactly how to bill for services means that psychologists and other mental health professionals are faced with more gray areas in the billing process. More uncertainty means the increased possibility of making mistakes. For example, if a patient comes in for 30-45 minutes but 1 hour increments are required for billing, it may prematurely use up the allotted visits Medicaid will cover. As a result, the provider may not be able to meet with the patient as many times as necessary for the appropriate therapy. Making mistakes in billing can also be costly. For example, according to Dr. Martinez, "if you bill Medicaid, and there is an error...they [Medicaid] will come back and then take their money back from you." On

the surface, this may make sense – money that was mistakenly paid should go back to where it belongs. However, if a mistake has gone undetected for several months the consequences can be disastrous for a small business. Dr. Martinez knew:

a lady who opened a business in another town in May [this interview was conducted the following October]... she got a letter that they're going to take back \$12,000 since May... So, she's provided \$12,000 worth of services that she won't get paid for...most of us don't have that \$12,000 just laying around.

Even if a mistake is made that favors the provider, all the money connected to the mistake must be re-paid to Medicaid and Medicaid must investigate the claim before any money is sent back (e.g., if a service is under-billed for \$200 but the provider was paid \$800, the provider would have to turn in all of the \$800 they had already been paid). If the case takes longer than 9 months to resolve (from the date the mistake was made, not reported), the money is forfeited. For Dr. Martinez, this was especially troubling because she had lost nearly \$16,000 when her billing agent accidentally under-billed Medicaid over an extended period. However, the risk of losing all the money she had already been paid in addition to the money Medicaid still owed her if the claim exceeded the 9 month deadline was not worth the risk and she said “I probably am going to have to eat that \$16,000.” Being willing to work with Medicaid, eat the cost of this mistake, and still be willing to risk financial loss in order to serve these patients also demonstrates how providers were willing to take a hit for the patients they served.

All the mental health professionals I spoke with commented on the amount of paperwork that was expected of them for each individual visit. Charla, an independent

private practitioner, works a lot with foster kids who are on the STAR Medicaid program. In this program the amount of paperwork for each child per month is a bit overwhelming because “they want once a month reports. It’s three pages of just questions, and it’s too much in addition to your progress note... It was a hundred pieces of paper, basically. And you have to handwrite them, because there’s no template.” In Brenda’s work with mentally ill patients, she was convinced that other healthcare offices would never be willing to do the amount of paperwork Medicaid requires them to do. In her opinion: “nobody’s going to want to do this, for the amount of work that is required by Medicaid, the paperwork, the mandates that the state has on us to do ... nobody’s going to do that for that. Doctors offices don’t have to do all that stuff.”

Pediatrics. Because Medicaid now uses a managed care system, the pediatric doctor has largely become the primary care physician for kids on Medicaid. Thus, these doctors face increased pressures through large patient loads, referrals to other healthcare providers, and follow-ups that other doctors do not see. Double and triple booking appointment times has become standard practice for some pediatricians, leaving parents and children waiting for scheduled appointments for two or even three hours on a regular basis.

Dr. Timothy said that the biggest challenge he faces as a pediatrician was not in referring his patients into specialists, but in dealing with transportation issues. He felt he could actually get his patients the appropriate care “99% of the time.” However, because specialists who are willing to take Medicaid generally work in large metropolitan areas, “getting them into see a specialist is a little bit of a challenge, not

because they're Medicaid...but geographically.” According to Dr. Timothy, “Medicaid helps them with gas and bus tickets, but there's extra paperwork, not that it's difficult and complicated, but it's just another step.” Sometimes this additional paperwork keeps patients from actually getting to their appointments – especially when they still have to coordinate school schedules, baby-sitting, time off from (hourly-paid) work, meals, etc. to travel 2 hours one-way for a single appointment.

Business type played a dramatic role in how workers made sense of their work environment related to Medicaid. For private practices, organizational rules and policies were used as tools for damage control to reduce unavoidable problems that came along with being a Medicaid provider. On the flip side, public non-profit organizations viewed Medicaid as a critical tool to help them achieve their own financial goals and utilized their own organizational policies and rules as a way of increasing Medicaid enrollment. Lastly, the type of healthcare service played a role in the kinds of rules and policies organizations employed with Medicaid.

Pressures of Working with Medicaid Patients

In addition to Medicaid policies and practices, personal and professional values toward indigent care, and organizational rules and policies dealing with business type, healthcare workers often experienced a great deal of pressure from patients and their guardians. The final portion of the first research question asked: ***How do healthcare service workers make sense of a complex work environment where they are constrained by (d) the pressures presented by Medicaid patients themselves?*** Four themes emerged from the data that demonstrated the kinds of difficulties workers faced

while interacting with Medicaid patients: 1) poor follow-through, 2) high no-show rate, 3) undisciplined behavior, and 4) crowding the office.

Poor Follow-Through

One of the principal challenges facing healthcare workers when dealing with Medicaid patients and their parents is lack of follow-through. Sometimes workers talked about a lack of discipline in following through on prescribed treatment. Dr. Allan mentioned that one challenge of working with Medicaid patients was that they would come in at age 3 and have to be sedated to take care of all the cavities, but then when he would see them again in two years they would be back to the same number of cavities as before and “it’s the whole cycle again” of hospitalized treatment. In his mind, it had a lot to do with “human nature” that people place value on the things that cost them something:

We see it with our commercial patients or patients that are paying cash, they have 3 year olds that have lots of cavities that we have to take to the hospital, and the parents have to dole out the money to get the stuff done...You’re going to pay attention that this doesn’t happen again next time, you know? Because there’s a lot of money that has to get paid to the dentist for the dental work...so if that happens, boy, you’re going to brush those teeth. Versus, in the Medicaid system, it’s kind of free. There’s no real value on it.

This frustration with devaluing healthcare services simply because they are free was not limited to dental work. Charla also noticed that Medicaid patients often wouldn’t follow through on her treatment plans. In her work, it was critical that parents bring their kids

who are having problems in on a regular basis so she is able to help them work through their troubles and get on their feet again. However, it was frustrating for her how often parents whose kids were on Medicaid would miss appointments and not follow through on prescribed therapy. The attitude seemed to be “if the kids are acting okay that day, they don’t worry about it that day. So if my appointment happens to be on the day they act good, I may not see them for a while.” When continuity and routine are critical to helping kids feel a sense of security, this can be especially frustrating for healthcare professionals. Charla said that money seems to play a role in how invested patients are in following through on their treatment plans:

Even if it’s only a dollar or three dollars – whatever it is. But there’s investment in it, and if you invest your money in it, maybe you’re going to follow through with some of the things we’re working on.

Other problems with follow through didn’t seem to be as much an issue of priorities as they were of actual ability. In Frank’s work as a psycho-social rehab case manager, his job was to work with people that weren’t able to manage their own schedules, keep up with ordering (or taking) their own medications, even though some of his patients still lived in their own homes and had jobs. Many times the illness would get in the way of good follow through on treatment programs that were recommended by their doctors:

Some of them are totally functional. They’re totally cool. Some of them are going to school and stuff. They’re dealing with their problems, but there’s a lot of clients here that just ... it’s like they’ve got the mentality as far as the social

mannerisms of responsibility and stuff of maybe a twelve year old, you know, so...it's real frustrating.

Frank has one client who had to go into her doctor for a review to make sure she still needed Medicaid and because of her illness, she had severe anxiety about the situation. This affected her so much that she nearly missed her required appointment. Frank said, "I don't think they [Medicaid] would have messed around with her. They would have just said you're not complying with this" and cut her off from the program.

Brenda said that some of the problems involve just getting clients to take the right amount of medication each day. She says when she starts talking with patients about how they are taking their medications that "it's amazing how many are not taking them the way they're prescribed." When she asks them how often they forget to take their medications each week she found that "90% forget to take them 1 to 2 days a week." This means that she and other caseworkers end up providing a lot of life-skills training. According to Brenda:

You try to work with them on finding where do you keep your meds? You're working with them on trying to come up with skill training that will help them be able to remember to take their meds more consistently. We may give them the 7 day pill counter, ask them to put it by their coffee cup or, what's your routine every morning?

Thus, patients' medical conditions play a large role in their lack of follow through which in turn creates significantly more work for mental health professionals assigned to work with them.

High No-Show Rate

This lack of follow-through was echoed throughout nearly all of my interviews with healthcare providers when they talked about the increased pattern of “no-shows” that came when working with Medicaid patients. In Julie’s optometry practice they had “about 45% new patient no-shows, and of that, it’s about 25 to 28% Medicaid no-shows.” While it’s important to keep in mind that no-shows are “on the rise all around” regardless of how patients pay for services, it’s still “much more so with Medicaid.” Dr. Allan found that Medicaid patients will “make appointments, and then they just don’t show up. That’s a huge thing.” Dr. Rasmussen pointed out a variety of potential reasons why Medicaid patients might persistently demonstrate poor follow-through like this:

By definition, people at the lower end of the economic scale, for some reason or another – mental illness, substance problems, simply pure laziness, or somehow not having gotten the education that they could have gotten if their parents had had more money or something – they don’t quite have their life put together as much as bank presidents, for instance. They’re not as organized and they don’t plan ahead as much, etc. And so... they probably are the same way with their health as they are with their economic situation.

As Dr. Rasmussen suggests, many times this lack of follow-through is simply part of working with indigent families. Charla also measured out part of the blame for the trend in missing appointments to the discouragement of patient responsibility under the current Medicaid program:

I've always felt, in a way, that the people who have other insurances with a co-pay...they have to invest in it money-wise, too, and you know how people are with money...they tend to want to be there for their appointment, or make sure that they've cancelled and rescheduled...They want that communication. When you have a Medicaid type of family, they kind of come in, they do their thing, and then they leave, and there is no investment other than their time, which, if you put it on the scale of money versus time, I think money is still their top priority.

As noted earlier, providers have found numerous ways of coping with patients who are sometimes unreliable. Dr. Matthews has placed limitations on the number of Medicaid patients per family scheduled at a single time. Drs. Allan and David have restricted seeing Medicaid patients to one day during the week, while Julie's optometry office has tried to spread out the risk of losing an entire day to no-shows by scheduling Medicaid patients in throughout their regular work week. In addition, almost all the practices I talked with said it was standard policy for them to make reminder phone calls for each of their next day appointments before leaving for the day. However, this wasn't always a guaranteed solution to the problem because "if you get their home number and all that...within the next couple of months...it's either disconnected or changed."

Julie mentioned that if the time came that their optometry started "knocking out insurance companies...[Medicaid] will probably be one of the ones to go first, because of the high no-shows, [and] the low reimbursement." In response to the trend in her Medicaid patients to drop appointments without warning, Charla established an office

policy where “basically if you miss one appointment, we’ll keep you on that next appointment. But if you miss two in a row, and we haven’t heard anything from you, we do take you off.” With the number of Medicaid patients she services, she admitted that “we’ve had to do that quite often.” Regardless of strategic approach, the problem of no-shows was an ongoing one with no clear or complete remedy.

Undisciplined Behavior

Lisa, head of optics, said it was hard watching some of the kids on Medicaid tell their parents to “shut up” in front of her. She said she could sit back for the first few times without wanting to intervene, but “when it happens five or six times, and you’re just like ... okay, at this point, Mom, you need to slap a hand or do something to say stop.” Many times, she said she felt like saying “Please discipline your child. Please, please, please.” In lieu of actually intervening, Lisa mentioned that she and the other optical staff cope by going to the back room and venting to the other workers about what they had just experienced. She shared the experience of one part-time worker at their office who struggled with wanting to discipline some of the Medicaid kids that came into their office:

Ruth, who’s one of our part-timers, she gets frustrated sometimes, like the kid will sit there and talk back to us while talking back to their mom. Like when we’re asking what happened, and they’re like, “Oh, I broke them.” There’s no remorse and the mom will say something, and they’ll basically tell the parents to shut up and you’re just kind of like ... and Ruth gets frustrated with that, like when a kid is rude. She’ll walk back to the room, and she’ll be like, “This is

what I want to tell them. You're six! Sit there and behave!" She'll come back and basically say what she would say to the kid. And she'll be like, "If that girl says one more word to me ..." and I'll be like, "Mm hmm ... go out there and fit the glasses!" And there are times, there are some people that some of us cannot deal with that we'll just pass onto another person.

While kids on private insurance were also out of control at times, workers said this trend was much more common, even to the point of being predictable behavior, with Medicaid patients.

Jerusha, a dental assistant working for Dr. David, had been on Medicaid herself as a child and thought that the stereotype of Medicaid patients being out of control and damaging property was pretty accurate. She commented that when things get really out of control she opens the door between the waiting room and "I just kind of say what I've got to say, without being rude or anything" because parents wouldn't intervene and get their kids under control. She felt a great deal of personal stress because parents "don't really tend to them [their children] well to keep them in order in public. They run around crazy, and then you've got the moms hollering at them and then the babies are crying."

Diane, an office manager, called such behavior talking "ghetto" and also said it was common in her dental office more with Medicaid patients than with private insurance. She said "we have some crazy stuff coming in here. They'll bring their whole family with them...I mean, as far as kids' behavior, they'll let their kids jump out in the couches up front. I mean, they're jumping up. Anything goes." She went on to

explain that when faced with this kind of situation she often had to intervene herself because many times parents sitting in the waiting room “just kind of ignore them [their children], like they’re not there.”

Dr. Allan identified a “lack of respect” among Medicaid kids and parents toward his property and toward the effort he was making to serve underprivileged people. While he was dedicated to providing services to Medicaid patients, he recognized that “they don’t really respect that you’re providing these services, you know? That you’re doing this stuff, and so they might be disruptive in the office.” In his mind, this was one of the biggest reasons why other dentists chose not to invest their time and property in working with Medicaid.

Crowding the Office

One of the major challenges facing Medicaid providers was dealing with the number of people Medicaid patients would bring with them to appointments. According to Diane:

They probably don’t have transportation for one thing, so they have to have somebody bring them, so they’ll come with that person, and then they’ll bring somebody else, and then all the kids, and it’s just crazy.

Dr. David had a small waiting room with “two chairs, for the parent and the child. Not the parent and six kids.” Having so many people in a relatively small waiting area complicated already challenging problems with maintaining order in the office. Diane said there were times when their office felt just like a “zoo” because of all the kids that were crammed in there and misbehaving.

It was common for Medicaid patients to have large families and bring all their children with them when only one child had a scheduled appointment. While Julie, who worked at an optometry, realized there were “big families with other insurance companies as well...you have that basis [large families] with the Medicaid...It’s low income.” This posed a challenge to their office in maintaining control over misbehaving kids. Julie admitted “there are days if we had to do it all day long it would probably run us nuts.” Things got so bad in Dr. David’s office that they started posting signs asking patients to bring only one other person with them into the waiting room and leave the others outside the door. It’s clear that Medicaid patients complicated the work experience for healthcare providers. These patients often didn’t follow through on clinical treatment plans and missed more appointments than private insurance patients. They also had a reputation for being “out of control” and for crowding providers’ office space with unnecessary people.

These data indicate that the constraints healthcare workers faced in working with Medicaid challenged them professionally and personally. They don’t trust and often don’t have access to formal support from Medicaid personnel when they have questions and yet some still feel that Medicaid is at least equal to or better than other insurance companies in some respects. They identify strongly with indigent healthcare, disagree with how Medicaid qualifies patients for services, and yet still feel committed enough to the program to continue serving as Medicaid providers. Their perception of this work environment is both complex and counterintuitive in many respects. Understanding and

evaluating how they cope as professionals within this complex environment is the topic of my next research question.

My second research question asked: ***How do the sense-making strategies of healthcare service workers help and/or hinder their ability to cope as professionals within such a complicated work environment?*** How healthcare workers made sense of their own work environment influenced how well they coped with the constraints that came from working with Medicaid. During my analysis of these data, sensemaking strategies emerged in two ways. First, workers enacted a strategy of self-reliance based on the actions they took to cope with the frustrations they encountered. Second, workers used discursive strategies to re-frame the meaning attached to the problems they faced.

Enacting Self-Reliance

Healthcare workers knew they couldn't rely on Medicaid support staff to get answers to their questions. However, their commitment to poverty care motivated them to enact alternative solutions to their problems through three forms of self-reliance: 1) relying on individual effort, 2) networking with other providers, and 3) relying on in-house experts.

Enacting Self-Reliance: Relying on Individual Effort

Most of the healthcare workers I spoke with didn't want to contact and speak with Medicaid personnel about their particular questions simply because they were "flippant" and "rude" to them on the phone. Dr. Martinez mentioned that during one discussion the person on the other end of Medicaid support became argumentative when she asked additional questions to ensure she was getting the right information. She later

found (after two more additional calls) that the man she had spoken with originally had told her to do the wrong thing. It was a waste of time and energy.

Experiences like this motivated healthcare workers to rely on themselves to find the answers they needed. Many respondents reported relying on a web-based clearinghouse to locate answers. For example, self-employed psychologist Dr. Martinez “spent hours and hours...trying to teach myself,” Kathy, an ophthalmology office manager, went on the “web to find answers” and, like Dr. Allen, called Medicaid support staff two or three times in a row to verify she was getting a solid answer. Julie who was an optometrist and optics office manager even had Medicaid support staff that told her to she should “Go look it [her information request] up” while Charla, a self-employed counselor and therapist, developed her own “system of checking to make sure that they [Medicaid] did acknowledge [her] claim, that it did go through.”

One obvious benefit to being self-reliant was that these providers could secure more correct information. Kathy and Dr. Allan called many times to verify the answers they were given so they could avoid making so many billing mistakes and learning by “trial and error.” Not only did self-reliance help providers avoid mistakes, it helped them gain solid knowledge of how the Medicaid program worked. Dr. Martinez learned answers to her question so well through her own research, after being fed misinformation by several Medicaid support staff members, that when she called back the third time she actually taught the staff member on the phone the correct answer to her question and walked them through the Medicaid website to ensure that they understood. Being able to find answers to questions on their own helped health care

workers avoid the discouragement and frustration that came from working with Medicaid personnel.

However, there were also drawbacks to service providers working on their own. Dr. Martinez was glad to have correct answers, but that information came at a cost – especially for someone who was self-employed and already swamped with clinical work. She wished she “didn’t have to do that [her own research]” because it was “very frustrating” keeping her up late into the night using up time she could spend on something more important. Both Kathy and Dr. Allan reported calling the Medicaid support line two or three times in a row to verify answers they got from Medicaid support staff. Individual efforts helped providers secure more accurate information but could also lead to discouraging results. For example, Amanda said that calling in for help from Medicaid support staff was “a lot of being on hold a long time...so I have to do it between appointments, and sometimes, if I’m on hold too long, I just have to hang up and start over. It’s pretty discouraging.” Ultimately, getting answers on their own bypassed a flawed support network but required a significant investment of time and energy.

Enacting Self-Reliance: Networking With Other Providers

When providers couldn’t get the help they needed from Medicaid support staff, some chose to network with other providers to solve problems and cope with frustration. Helen, the financial manager of a non-profit mental health organization, was a good example of this. When Helen couldn’t get answers from Medicaid personnel she and 38 other financial managers in similar organizations across the state “developed a group”

for support. Meeting together “at least every six months,” this group of professionals was large enough to leverage support from Medicaid personnel that no single person could get on their own. For example, Helen said she “never saw [a Medicaid representative] come by” her workplace to ask how she was doing or if she had any questions. Yet, as a combined group they scheduled speakers from the Medicaid office to come and field questions on common challenges they were facing.

However, because their organizational policies were unfamiliar to Medicaid support staff they often didn’t know how to answer their questions. When even the speakers couldn’t answer all their questions “we just try to solve things within ourselves.” With so many experienced members in their group it was likely that someone else had gone through the same experience. In addition, the network they established provided ongoing access to one another in addressing issues as they arose. Working with other professionals that had similar questions about Medicaid policies and procedures not only increased the likelihood of finding someone who knew what to do, but also reduced the amount of time each person had to spend in finding relevant answers. In Helen’s group it was standard practice that “one person will call if we all have a similar problem.” By taking turns hunting down answers to shared problems, they didn’t have to invest already scarce time in tracking down every answer themselves.

Other healthcare workers also relied on networking with fellow Medicaid providers to overcome the information barrier with Medicaid support staff. Dr. Allan’s secretary, Wendy, often relied on other competing dental practices. According to Wendy, “they were all very nice and going, ‘Oh, that’s fine, just give us a call,’ so I was

happy.” Charla remembers “when the whole split between STAR Medicaid and Medicaid came. No one from Medicaid told me about it. It was another clinician that said, by the way, do you know all your foster kids will have a different insurance?” Dr. Martinez talked with other professionals in her field when she couldn’t get a straight answer from phone support staff while Amanda had “a real good social network in town...who keep in contact with one another.” As a private practicing therapist, Amanda wasn’t “shy about getting on the phone and calling and asking questions.” These healthcare workers demonstrate a strong reliance on other Medicaid providers who deliver similar healthcare services as a means of enacting self-reliance from Medicaid support staff.

Healthcare workers also relied on each other to vent frustrations with Medicaid policies and patients. Dr. Martinez mentioned that she often spent time sharing troubles with several of her professional friends who shared her views on Medicaid policies and practices. Wendy said there were times when she would call another dental office just to talk with someone who was as frustrated as she was with the Medicaid policies. Lisa, director of optics, said they dealt with Medicaid frustrations on a daily basis by going “in the back room, and we’ll be like, ‘Can you believe that person?’” Other times she said they would “walk back and we’ll be like, (*whispering*) ‘They’re back again!’ ... and we’ll just kind of joke about it and then it just kind of relieves that person and then we’ll move onto the next person.” Being able to vent and “joke about” these issues gave healthcare workers a productive way to manage the daily stress they felt from working with Medicaid.

Enacting Self-Reliance: Relying on In-House Experts

Relying on in-house experts was another way healthcare workers enacted self-reliance within their immediate organizations. Dr. Timothy didn't have to worry about the billing side of Medicaid at his clinic because they had an in-house Department of Health Services (DHS) worker to take care of that for them. When he had a problem with Medicaid at his pediatric clinic he just went "to our [Medicaid] clerk here and [said], 'This person's getting screwed somewhere somehow, can you fix it?' and then she makes it happen." He didn't have to learn the policy or spend his own time trying to figure out where things went wrong because he had an expert who could make "it happen." Alicia, who works the patient registration desk in the same clinic, said, "It's easier to go through her [the Medicaid clerk] because she just deals with our patients." While many times paperwork could take weeks to process, their in-house representative could get the paperwork processed in a fraction of the time. In addition, because her entire focus was on the clinic this (DHS) worker understood how their organization worked and was able to deal with context-specific problems in a timely manner.

As a new mental health caseworker, Frank admitted that he really didn't know all that much about how Medicaid worked but relied on Natalie who was one of two in-house Medicaid experts employed at his clinic to help him resolve Medicaid problems. Natalie worked for the mental health organization and was not employed by the DHS, but she did have extensive experience working with Medicaid and had a formal position as a Medicaid expert within the organization. Having an in-house expert to turn to allowed Frank to keep pace with other more experienced caseworkers and focus on the

patients he was working with rather than memorizing all the policies associated with Medicaid.

Diane, who worked in another office connected to the same organization, recognized “there’s one lady that works on the MH [mental health] side. She’s been here for like, 10 years, and so I ask her everything if I don’t know...she knows everything.” Whenever she had questions about “what forms I need to turn in” she would go to Natalie who “knows all the numbers and stuff.” Even seasoned professionals like Kelly, a caseworker with more than 20 years of work experience, said she relied heavily on Natalie to answer questions, deal with patient application problems, or to help her patients re-apply for Medicaid services. By enacting self-reliance through their individual efforts, networking with other Medicaid providers, and relying on in-house experts, healthcare workers were able to deliver healthcare services in spite of Medicaid’s poor provider support. Enacting self-reliance through individual efforts helped workers get answers but was time intensive work that often led to learning by “trial and error.” Networking with other Medicaid providers helped professionals to speed their learning curve, share the workload, leverage additional support from Medicaid personnel, and gain social support from other professionals who shared their frustrations. Relying on in-house experts reduced the learning curve for new professionals and gave healthcare workers more time to focus on their patients. Overall these last two forms of enacting self-reliance seemed to be especially beneficial to healthcare workers. I will now discuss the discursive sensemaking strategies these professionals used to cope with the constraints they faced.

Minimizing, Blaming, and Detaching

Healthcare workers felt great animosity towards the Medicaid program. When asked what it was like to work with Medicaid, they talked about the outrageous behavior of Medicaid patients. However, in building such strong arguments against Medicaid through these descriptions, they faced a staggering question which I often asked during my interviews – why were they still working with Medicaid? In an effort to make sense of their dedication to provide services for Medicaid patients in the face of such damning problems, three major sensemaking approaches emerged from the data: minimizing the problem, blaming the parent and/or the program, and detaching the patient from the program.

Minimizing the Problem

This sensemaking strategy attempted to reduce the perceived size of negative patient behaviors so that healthcare workers could fully acknowledge justifiable frustration with Medicaid patients while maintaining their allegiance to being Medicaid providers. Some healthcare workers attempted to minimize the problem by quantifying the percentage of patients that abused the system compared to those that seemed to really need the help. For example, Dr. Rasmussen's office manager Kathy said she would "never forget" the woman who bragged about getting a new Cadillac after bringing several children in for care on Medicaid because it "just seems like there is something wrong with that picture." However, after saying this she quickly added that the "majority of them [Medicaid patients], I truly believe that they do need it."

Similarly, Dr. Timothy, a pediatrician, described his frustration with patients who scheduled office visits to re-stock their Tylenol because Medicaid would pay for it if prescribed by a doctor. Other Medicaid patients abused his time by asking for a doctor's note when it was really to save the parent from a truancy violation when their child had skipped school. After describing these negative experiences and his frustrations with Medicaid he admitted that "those kind of scenarios don't happen frequently" and are part of a "10% scenario." Dr. Timothy argued during his interview that the Medicaid patient coming in a "car with fancy rims on the wheels...coming in trying to get free healthcare for their child" was an obvious "stereotype" and only accounted for "10-20%" of the Medicaid patients he actually saw. Most of them, he said, were "working and they need this service." Framing these negative experiences as part of "the 10% scenario" helped him still feel fulfilled "working in an underserved clinic" where he could do "just a little bit more than just my part" without negating his "frustrations and some of the screwy stuff that goes on" in his work as a Medicaid provider.

In a related discursive strategy, healthcare workers minimized the problem by maximizing the provider's commitment to helping indigent groups. Maximizing the provider's commitment to helping indigent groups minimized the relative size and scope of patient abuse without diminishing the very real frustrations that followed that abuse. For example, Julie described the stress that came from increased Medicaid no-shows and from Medicaid patients bringing their entire families in for a visit. However, she admitted that while "there are times when you've got ten kids in the waiting room and they're running around and screaming...that's the whole point. It's low income. It's to

help the ones with more kids.” She didn’t diminish the size of the problem but stated that because the business is owned by “a Christian family man... it’s never a point where we had to stop that [being a Medicaid provider] and most of us that work here are pretty much the same way.” Those who were committed to indigent care weren’t too surprised that helping “the ones with more kids” can get tough sometimes – after all, personal sacrifice is “the whole point.” By reinforcing the values that she, the owner, and the other staff in her office held she could fully acknowledge the negative behaviors of Medicaid patients while simultaneously reinforcing her commitment to continue serving them in spite of those challenges.

Blaming the Parent and/or the Program

Blaming was a sensemaking strategy that focused on shifting responsibility for the problem away from the patient to the parent or the Medicaid program itself. This allowed healthcare workers to cope with Medicaid abuse without losing their commitment to indigent healthcare because they could blame someone or something other than the patient for their negative experience. Tiffany, a dental assistant, clearly targeted parents for the abuse she saw with Medicaid patients, stating “there’s parents that drive up in nicer cars than I have...there’s a lot of that...I don’t feel it’s the kid’s fault. That’s the parents doing... when it comes to kids, it’s not the kids’ fault.” Because children were the primary patients at this clinic, differentiating between the parent and the child in this comment allowed Tiffany to fully commit to condemning the abuse without damaging her commitment to the children (who were innocent) coming to her office for treatment. Megan, a front desk clerk at the same clinic, said that “when

you set appointments for them [Medicaid patients] and they don't show and you know that they need it" she didn't blame the child since "it's the parent that's not budging." While getting their teeth checked was "the best thing for children" the hardest part was "getting the parents to play their role."

Private practices also blamed parents rather than the patients for the problems they experienced. According to Dr. Allan, "it's just kind of a destructive path, and sometimes you can't really get the parents on board." Jerusha, a dental assistant at a private practice, also felt "a lot of the times, it is the parents that really just make the kids so nervous" out in the waiting room. It was significant that when talking about all the "crazy" stuff that happens in the waiting room with Medicaid patients she framed parents as the guilty party. She saw "a lot of people holler at their kids over nothing, and cuss them and stuff. It's just like, 'Whoa, lady, calm down!' So, I think a lot of it is the parents." Framing parents as the guilty party allowed these healthcare workers to fully express their frustrations with the negative behaviors they saw without losing sight of their commitment to providing quality service to the patient.

Other healthcare workers made sense of negative patient behavior by blaming the Medicaid program itself for problems they experienced with patients. Lisa, working as director of optics, was frustrated with the abuses she saw because "we're letting them [abusive Medicaid patients] get away with too much." She felt the Medicaid program needed to have "a little stricter" policies because "you can break your frames as many times as you want to, and we'll replace it for you." Such policies would prevent people from "constantly breaking [their glasses] and the feeling you're entitled" and "would

look more deeply into a person's financial history" to prevent fraud from occurring. Dr. Timothy also blamed Medicaid for being a "convoluted" system where policies let patients get away with too much. He criticized the program for covering medications patients could get over the counter like Tylenol. While they were frustrated with the choices patients made, these healthcare workers clearly blamed Medicaid for the problems they experienced. Megan believed much of the abuse she saw with Medicaid patients was due to how Medicaid determined eligibility since she thought there were "a lot of people that come here that maybe could do well without it [Medicaid]."

Detaching the Patient From the Program

Healthcare workers engaged in detaching the patient from the program when they discursively separated the patient from their affiliation with the Medicaid program. One of the best examples of this came from Dr. Allan who tried to separate himself "from the whole social aspect of it [referring to Medicaid abuse]." He said he would do as much as he could "as far as educating them and doing all this stuff [dental work] and let someone else worry about if they're taking advantage of the system or not."

Other professionals detached the patient from the program by framing patient affiliation with Medicaid as something separate from how they treated patients on the job. Jennifer said in their office "they don't look at, 'Oh, this is a Medicaid patient.' They don't...they'll come back to the lab and say, 'You know, this kid has a strong prescription and doesn't have any glasses. Can you etch these for me right now, so they can leave and go to school with them?'" According to Jennifer, people in her office were more interested in helping a child see than in labeling them as a Medicaid patient.

Tiffany said that “as for insurance [patient affiliation with Medicaid] and the way they are [patient behavior], that’s all treated the same. It would be very unprofessional to treat them differently.” Megan agreed that it was “unprofessional” to provide different levels of service to patients based on which insurance they used. After talking about her frustrations with patients that seemed to be abusing the Medicaid program, Kathy said “they would never know that I feel that way. I still treat them the exact same way [as patients with other insurance].” Working at a public nonprofit, Debbie said “that’s what I’m here for, to make sure that they get the care that they need...because it’s important. It doesn’t matter if they are a Medicaid recipient or not. The thing is, that patient is what’s important.”

The clear benefit of detaching the patient from the program was to allow healthcare workers to treat patients equally (e.g., “professionally”) regardless of Medicaid status. However, professing this in word and doing this in deed were two different things at times for some healthcare workers. For example, Megan agreed with detaching the patients she worked with from the Medicaid program and said she tried to treat everyone the same. However, during our discussion she admitted that it was hard not to notice at her part-time job at Wal-Mart how Medicaid patients spent their money. When they came into their office for dental services, she knew what they could buy and led her to believe they were abusing the program. Being able to actually detach a patient from the program proved to be far more difficult in practice than it was in word after Megan knew what their buying habits were. While it seems a bit idealistic to think that healthcare workers completely separated the patient from the program, this discursive

strategy did help them make sense of a difficult problem they faced as professionals. Being able to cope with Medicaid as a healthcare provider was a combination of enacting self-reliance and using talk to manage how they viewed patients, parents, and the Medicaid program itself. Embedded within each of these strategies were core values and beliefs that shaped how healthcare workers viewed themselves and the work they did as Medicaid providers. While many of the sensemaking strategies they used helped there were obvious ways that some hindered their ability to cope as professionals within their work environment. In the following research question I will address the impact these sensemaking strategies had healthcare workers' view of themselves and the work they did with Medicaid.

The third and final research question asked: ***How do the meanings that emerge from sensemaking communication shape how healthcare service providers see themselves as professionals and how they view the work they do?*** How healthcare workers made sense of their experiences with Medicaid as providers shaped the way they viewed themselves and the work they did. Emerging from these meanings were at least four identities that shaped how they viewed their work: 1) disciplinarians, 2) problem-solvers, 3) advocates, and 4) benefactors.

Medicaid Providers as Disciplinarians

Healthcare workers saw themselves as disciplinarians whose job it was to teach, set boundaries, and punish. Providers believed it was their job to discipline Medicaid patients by teaching and training them to behave appropriately. For example, most of the Medicaid patients seen at Julie's office were kids on the program. She said it was

their collective experience with these kids through other roles that gave them an edge in dealing with an otherwise challenging office environment:

Most of us here have dealt with kids in one position or another...It takes a special person to be able to handle kids all day long. And most of us are either parents, grandparents, deal with kids at school, so ...

According to Julie the kind of person who is able to handle “kids all day long” is a “parent, grandparent,” or someone that has worked in the school system. In each case, the role includes being able to discipline a child’s behavior. It is significant that Julie references the roles of parent, grandparent, and teacher when describing the qualifications of the staff in her office. Using these roles shows not only how she made sense of herself professionally (i.e., a disciplinarian to the patients that came in), but also how she perceived the work she did (i.e., enforcing rules, teaching correct behavior, disciplining).

Part of being a disciplinarian is engaging in constant education, teaching, and training activities. Brenda, director of nursing for a mental illness organization, had many patients who were not taking their medications “the way they’re prescribed.” This meant “there’s a lot of education, education, education. There’s just a lot of education we have to do.” Most of her time is spent “trying to come up with a skill training that will help them be able to remember to take their meds more consistently. We may give them the 7 day pill counter, ask them to put it by their coffee cup or, [asking] ‘what’s your routine every morning?’” Brenda saw herself as a teacher, which influenced how she approached her patients when they didn’t remember to take their medications. As a

disciplinarian, she was more interested in locating the skill they needed to perform the task than in coming down on them for making mistakes.

For Dr. Allan, one of the best things about seeing kids on Medicaid was that “you can educate them” on the important dental habits they might not be getting “from their schools.” He wanted to “make some type of impression on them [Medicaid kids]” since “they might not be getting that from their parents.” Seeing himself as a disciplinarian motivated him “to be sensitive to their [parents’] needs” and adapt his explanations and teaching style to the knowledge “they are coming in with...[and]...the way they’re thinking is.” He was concerned about accidentally offending parents even though he was trying to help them correct damaging practices that harmed their children. As his comments demonstrate, his sense of what it meant to be a disciplinarian extended beyond the child he was treating to educate parents too.

Being a disciplinarian shaped how healthcare workers interacted with Medicaid patients. Workers talked a lot about setting behavioral boundaries for Medicaid patients. For example, when Dr. David sees kids “running around and jumping on my chairs and stuff and you kind of got to go in there and say, “Look, guys. Sit down.” In addition to talking to patients “without being rude” Natasha, a dental assistant, said that “if it gets rowdy up there [in the waiting room]” she would simply “shut that first door [the door between the waiting room and the treatment room]...I just shut it.” According to her, patients should take the hint because “that should be a telltale sign, hey, you’re being too loud, you’re causing me to close this door.”

Lisa wasn't above using guilt to set a boundary on behaviors she didn't agree with. When kids came to her office and it was obvious they had purposely broken their glasses she wouldn't let them get away without feeling guilty about what they had done. She wanted:

to make them feel guilty about it, just to where maybe they won't want to come see me again because last time, I was kind of like, 'What'd you do it? What happened? Well, why'd you step on it? Why weren't they on your face?' Like, we ask it really nicely, but at the same time, we're trying to make you feel like you knew you were doing something you weren't supposed to do, and you need to stop doing that.

Lisa wanted to hold them to the line so that they would think twice before they "accidentally" broke their glasses again. It was her job, as a disciplinarian, to help Medicaid patients take care of their glasses. Getting them to feel embarrassed by asking a few firm questions helped her accomplish her objectives and fulfill her role.

Others said sometimes they had to get "mean" and be "firm" in order to set boundaries for Medicaid patients. When a Medicaid patient got "mouthy" with her about a policy they didn't agree with, Megan said she only had to make her tone "pretty firm. You know... you get that firm voice." She admitted "If you start out, like really nice and kind" they might walk all over you, so "you don't start out mean, but trying to get something across." Once she's firm with them she said they get the message pretty quick and stop trying to contest something that isn't going to change. You can almost

pretend you are listening to Megan talk about her parenting techniques with an unruly child as she talks about how she deals with Medicaid patients that get out of line.

Charla, who counseled teenage foster kids on Medicaid, also said she was “pretty rough on them, and they like that for some reason. And they come back, and they want to come back.” She explained that she was “mean” to her patients, but “in a healthy way” by helping them understand the consequences of their choices. Similar to Lisa’s efforts to induce guilt in her patients, Charla wasn’t willing to budge on teaching her patients about the consequences of their choices even if it meant she had to sound a little “mean” sometimes. They knew the boundaries and seemed to respect Charla for setting them.

Healthcare workers weren’t only interested in establishing boundaries, they also had to enforce punishments when those boundaries were crossed. As disciplinarians, their motive for enforcing rules was to discourage Medicaid patients from breaking them. For example, Lisa’s optics department made it a policy to give each Medicaid child a hard case when they came in for glasses to help them avoid breaking their glasses so often. Diane said their no-show policy at her dental practice could be devastating for Medicaid patients because “they [Medicaid patients] know that there’s very little, or there’s a limited amount of dentists here in town that accept Medicaid, so if they mess it up here, who else are they going to see?” In order to help them comply with this policy they would:

send them a letter prior to their appointments stating... when they come in, we need their Medicaid card, we need the paperwork filled out that we send to them

brought back in, and...the rules regarding Medicaid, stating that if we don't get a 24 hour cancellation [they would not be allowed to get service]...And then we do call a day before the appointment to also remind them.

As disciplinarians, the goal of disciplinary action was also to help Medicaid patients change and/or avoid unacceptable behavior. When optics patients used Medicaid to buy frames for their glasses they could choose plastic frames (covered 100% by Medicaid) or they could choose metal frames that were usually more stylish (Medicaid would pay the cost of plastic frames and the patient was expected to cover the difference out of pocket). Recognizing this, while Medicaid required their office to replace broken glasses for anyone under age 18, Lisa and her optics staff decided that “if they do break a metal frame, and they get a new metal frame, we charge them the \$18 [difference] again” to discourage them from breaking their frames. This disciplinary technique seemed to work “for a little while” as some parents would take their child to task and:

look at the kid, and be like, ‘All right, you owe them \$18,’ because that’s how much it is for a metal frame upgrade. Or they’ll downgrade them to plastic, and the kid will be like, ‘I don’t want plastic,’ and the mom’s like, ‘Well, quit breaking them.’

Requiring the patient to pay the difference between the fully covered plastic frames and more stylish metal frames reinforced the lesson optics personnel were trying to teach (e.g., don’t break your glasses on purpose.) As disciplinarians these optics workers were interested in curbing bad behavior not just punishing someone for breaking a rule.

Healthcare workers thought requiring some kind of monetary payment for services would help reinforce the behavior changes they were striving for with their Medicaid patients. For example Charla said “money is still their [Medicaid patients’] top priority... if you invest your money in it, maybe you’re going to follow through with some of the things we’re working on.” Dr. Allan agreed, believing that one of the reasons he saw so many more Medicaid patients with severe cavity problems was because parents on Medicaid didn’t have to pay for filling the cavities themselves. Those who had to pay a lot of money “to the dentist for the dental work” were more motivated to prevent cavities, but for Medicaid patients “there’s no real value in it [preventing cavities].” Lisa and her staff even talked about charging a small \$5 fee the second time a Medicaid patient asks for a replacement for broken glasses and raise the fee \$1 for each additional time they need a replacement. This, they hoped “would stop them if they had to pay...each time they broke” their glasses. As these examples illustrate, being a disciplinarian meant establishing the boundaries of behaviors that were acceptable to healthcare providers and then using a “firm voice” and even discipline to reinforce those boundaries when Medicaid patients stepped out of line.

Medicaid Providers as Problem-Solvers

Medicaid providers saw themselves as problem solvers. Many times this meant healthcare workers were solving problems for forgetful Medicaid patients. For example, when a patient would “walk in and say, ‘I’m a pending case,’ or, ‘I lost it [their Medicaid card],’ or ‘My son tore it up,’ or something” Megan, the front desk worker, would just “go in the computer and look it up and make sure that it is valid.” To her,

solving problems like this were “easy” because it only took “a little time.” However, it became so common for Sherry to look up Medicaid information for patients in her office that she began to feel like they just “expected” her to do it for them all the time. She said “there’s been plenty of times where they’ll say, ‘Well, I don’t have my Medicaid card, but you know, you can look in your computer.’” Similarly, Diane wasn’t happy when Medicaid patients showed up “with no Medicaid card” since it meant that “now I’ve got to go in the system, try to find their number.” Being a problem solver for these workers meant working through feelings of frustration.

Other healthcare providers demonstrated how they viewed themselves as problem-solvers by the initiative they showed. When Brenda was frustrated with getting quizzed over the phone about Medicaid codes, she distributed “cheat sheets” to her staff so they could always say the answers in the way Medicaid personnel wanted. Kelly demonstrated significant initiative for her Medicaid and non-Medicaid patients who didn’t have transportation to appointments by offering to give them rides. Debbie said when patients came in to apply for Medicaid she would “download the patient information form [ahead of time] so that they go ahead and fill it out there if they need help. When “some can’t read or write” she would “actually help them with filling that form out.”

Being a problem solver meant demonstrating problem solving initiative in other ways as well. For example, when faced with little or no support from Medicaid support staff in learning the Medicaid system, some respondents came up with “other ways” of solving their problems. Dr. Allan didn’t stop trying to get help from Medicaid personnel

just because the support staff couldn't help him – he went to conferences and networked with the Medicaid's dental directors to get the answers he needed. Similarly, Dr. Martinez spent hours of time searching for information on her own when she couldn't get answers from support staff. Additional extensive examples of the problem-solving skills demonstrated by Medicaid providers can be found in the previous research question responses (e.g., relying on individual effort, networking with other providers, and relying on in-house experts).

Other healthcare workers talked about themselves as problem solvers because they were interested in helping Medicaid patients get what they needed. Debbie said she helped “some [patients who] can't read or write, and I'll get to actually help them with filling that form out.” In her mind, helping other people get the services they needed meant “saving a life” and was part of her “calling.” Wendy said she wanted to help “everyone to get what they need” and if they needed something she was “going to help them try to find it if I can.” Frank said he often found himself just helping his clients keep scheduled medical appointments or even performed tasks as simple as reminding his patients to take their “meds” each day. Henry, a program manager for a mental retardation center, said that a major aspect of his job was to help families who “really don't know what's out there... tap into some of the resources” available for them through Medicaid and within the community. Elaine's job as a service coordinator emphasized problem-solving even the most basic “economic” issues like getting food into the home, coping with “family dynamics,” and assisting families in locating healthcare providers that could meet the needs of their disabled family member.

Kenesha was often frustrated when patients didn't call her at the first sign of Medicaid troubles so she could track down solutions before they were kicked off the program.

Some workers believed they couldn't step away from work even for unexpected circumstances without causing additional problems for their patients because their patients had become so dependent on them for help. As a mental health caseworker, Kelly had been driving many of her patients in for appointments because they didn't have transportation of their own. However, after she broke her elbow and wasn't able to work, those patients were no longer coming in for their visits. When thinking about finding a new job her patients told her "Well, if you leave, we're not coming back, so please don't leave us." Unhappy with her job, she still couldn't leave her patients because they depended on her to meet their needs.

Medicaid Providers as Advocates

Healthcare workers saw themselves as advocates for non-Medicaid patients, Medicaid patients, and the Medicaid program itself. Regardless of the group they were advocating for, being an advocate meant standing up for a marginalized or underprivileged group. Some healthcare workers didn't want non-Medicaid patients to feel uncomfortable around Medicaid patients. Diane was concerned when "you have them [Medicaid patients] in here with your normal patients, and what are your normal patients thinking? I don't want to be there, they've got a zoo going on there." Jerusha, a dental assistant in that office, realized Medicaid patients were "hard on" their kids saying things like "Get your butt in there!" and "hollering" at them. When I asked her how people who were not on Medicaid reacted, she said "that's why we keep Medicaid on

Mondays.” The policy of separating Medicaid patients from ‘normal’ patients was to protect the non-Medicaid patients from having a bad experience in their office.

Some workers were advocates for non-Medicaid patients because they believed they should have a say in where Medicaid dollars were spent because it was their money paying for the program. According to Maria, a dental assistant, “As a taxpayer, that [Medicaid abuse] does upset me. Me, personally, because there are so many children that are neglected out there and they can’t get Medicaid.” Maria was upset because she felt that her money was being sent to the wrong people. In her mind it should be going to patients whose “teeth are badly decayed and Mom can barely afford to do one tooth at a time” not to people that drove “Escalades” and “Cadillacs” Nancie, a nurse at a mental health clinic, said she had “some people that come in here and I think, ‘My gosh, why don’t you have Medicaid?’ You know? I mean they have nothing...Medicaid would help them in getting on their feet.” Tiffany agreed that more needy families should be the ones who got her money because “there’s people that need it and that don’t get it.” According to Tiffany, the ones that “need it and don’t get it” should include people like her “struggling” friend who works “two or three jobs just to make ends meet” but still can’t qualify for Medicaid.

Kelly was an advocate for non-Medicaid patients too, but for an entirely different reason than other healthcare providers I interviewed. She felt her organization favored Medicaid clients because Medicaid guaranteed a steady income but neglected non-Medicaid clients because they couldn’t always pay as much (non-Medicaid clients were charged using a sliding fee scale). After a heated e-mail exchange with a supervisor who

was upset Kelly had been spending too much time with non-Medicaid clients she was told she had “a bad attitude.” Kelly was “okay” with this since she was “advocating for my client.” What’s more she “told them that ‘I will have a bad attitude when it comes to my clients, because that’s my job.’” Being an advocate for her clients meant placing her clients’ welfare above her supervisor’s interests. It meant she had to choose sides.

Some healthcare workers saw themselves as advocates for Medicaid patients themselves. Diane fully recognized the challenges that came into her work life because of Medicaid patients, but also thought they were being treated unfairly. Since, she had “worked with Medicaid before” she recognized that, in general, Medicaid patients weren’t given as much time during appointments as “normal” patients received:

like with cleaning appointments. Normal patients with insurance, regular insurance or cash pay, they come and they get an hour [and] 30 minute appointment scheduled. We have time to do everything that we need to do at that appointment – x-rays, cleaning, whatever needs to be done. As far as Medicaid patients, being that we have to see a whole lot of them to make up for our production, I just feel like their time is shortened for their cleanings.

This bothered her since she thought “people should all be treated equally, regardless of what kind of insurance they have, or what their background is, or whatever. I mean, you’re here to treat people, not just ... you know?” While she did whatever she could to help them she admitted “I can only do so much...if I schedule more time, they can cut the treatment off, so it doesn’t matter.” In her position, being an advocate meant doing what she could to help even though it may not make a difference in the end.

Wendy, an office manager, saw herself as an advocate for Medicaid patients because she had “been there, done that” as a former Medicaid patient herself. During one phone conversation she was:

getting the children’s information, and I’m like, ‘well, is there any insurance we need to be aware of?’ She was like, ‘We have Medicaid,’ and I said that’s fine. And she goes, ‘What?’ She’s like, ‘Everyone else that I’ve called has just totally turned me off as soon as they found out I had Medicaid.’ And then when she came in and she was seen, she was like, oh, we’re so nice. And I was like, well, you know?...There are reasons sometimes that people have to use it, you know? I said, ‘Nothing wrong with it.’

Wendy understood what it was like for Medicaid patients to feel self-conscious and be embarrassed when calling providers. She also knew what it was like to have healthcare providers get “turned off” when they learn she was on Medicaid. Her past experience as a Medicaid patient informed how she approached her job as an advocate for the patients that came into their office. She was able to approach her patients with greater sensitivity and anticipate their concerns. As an advocate, Wendy’s job was to reassure Medicaid patients they were not “bad” people as “there are times in our lives we have to go through that ... and it’s okay.”

Some saw themselves as advocates for Medicaid patients because it was part of their job description to advocate for their patients. Henry worked as a program manager for a mental retardation clinic but felt his primary role was in “dealing with families who have school age kids” by acting as “a speaker for them in the school system.” Because

“some families want us to help them [work with Medicaid], and some want to do it themselves” part of what it meant to be a good advocate for these workers was learning to “just step out of it” when a family wanted to take care of things on their own. In these cases, being a good advocate meant not acting as an advocate. As a service coordinator working under Henry, Elaine said the families she works with “rely on us to help them link through the Medicaid system” to a variety of community resources. Because there are so few providers in the area willing to accept Medicaid, many times acting as an advocate for these families meant doing a lot of tedious work like “leaving messages and then following up...playing phone tag and trying to make sure I get to talk to the right person.”

Other healthcare workers saw themselves as advocates for the Medicaid program itself. Dr. Allan said he thought every provider “should do it, even to whatever extent they want to” while his office manager, Wendy, was more emphatic saying that “If you need it, use it. You know, don’t just go, ‘oh, I really don’t want to do that.’ Or, ‘I’ll just suffer and ...’ No, don’t do that. Do it.” Amanda told me she liked working with the Medicaid program and wanted other providers to know it when I scheduled my interview appointment with her. She got “an electronic deposit every week” that helped her “keep the cash flow going.” Working with Medicaid also helped her connect with foster kids, which meant more business. As an advocate of the Medicaid program, she believed Medicaid made her work easier. Even when she acknowledged that “it’s a lot more paperwork to document” she still framed the program as “well-intended.” Similarly, Diane admitted, “if Medicaid wasn’t part of our practice, we would probably go out of

business. We probably wouldn't have a job...Medicaid makes up a lot of our production. It's job stability for me."

Medicaid Providers as Benefactors

Healthcare providers also saw themselves as benefactors to the Medicaid patients that walked through their doors. They believed they were they were personally connected to how their patients were getting free Medicaid services. Some believed they were actually paying for the services Medicaid patients received. Maria identified herself as a "taxpayer" to justify why she felt like she should have a say about who received her money. Similarly, Tiffany recognized "there are those people that do it, taking advantage of WIC, taking advantage of all the government things. That takes it from us, because Medicaid and stuff, that comes out of our pay, so that takes it out of us." Her gripe over Medicaid and other welfare fraud was that the money came out of her pay. This was personal.

Diane and Jerusha both recognized that dental patients really didn't have many other options for service. According to Jerusha, "not many dentists around here...take Medicaid, so if they mess up with us, they're going to have to drive to Houston." Since there weren't very many service providers, Jerusha felt that what they offered patients should be valued by those patients. Further, if patients didn't conform to office policies then they would "mess up" and would have to make the extra effort "to drive to Houston" for service. Essentially, the service they provided was used as leverage in an effort to discipline their behavior. It was something that could be taken away by those who were providing it.

Some providers were *willing* benefactors. They recognized they were providing a significant service to Medicaid patients, but they did so willingly and often with enthusiasm. Others were more *grudging* benefactors who would provide services, but weren't happy doing it. Charlie, who runs a large mental health clinic, was glad they could offer services to Medicaid patients because those patients:

end up being more productive...the more productive they get, they get out there, they get jobs, so they're out there spending money and [are] good for the society and in a better shape than going down the street talking to themselves.

To Debbie, helping these patients was a chance for her to help "save a life." Alicia was glad they could help provide services to Medicaid patients at her family clinic because they "probably didn't think they were ever going to be able to see a doctor because of money."

Some providers were either more willing or more grudging as benefactors based on how the patients themselves behaved. For example, Lisa said being grateful and submissive made a difference in whether she wanted to help Medicaid patients. For the Medicaid patients that were "really grateful" she was "totally okay with doing Medicaid." To illustrate her point, she shared the following example:

we have one, her sister and brother-in-law got in a car accident, so she took over their four kids. So, she has three and now has her sister's four, and so of course, they're now all on Medicaid, because she now has seven kids. And so for them, when they all came in and everything ... I mean, she was like, "I don't know what they can get, things are kind of tight now. I know these three are definitely

going to need glasses,” and she’s trying to ... because her kids are used to ... both sets of kids are used to going and getting nicer glasses, because they were on their parents insurances, and they were on theirs, but when you suddenly get seven ... And so, she came in, and she was very, “Oh, thank you so much! Oh, yes, those will work perfectly. You have a great selection. I’m glad ...” you know. And so then, for that person, like, I’m totally good with doing it, because I felt like you’re helping out your deceased sister. We’re helping you try to get through this, so then you feel totally good about it

In this example not only did this patient demonstrate gratitude by thanking Lisa and complimenting their “great selection,” she also was doing all she could to handle a situation she had not done anything to deserve. Nancie commented about this when she criticized Medicaid patients who “can afford to get [their] nails done...[but] can’t afford to pay \$30 for a prescription.”

Other times Medicaid patients based their willingness to help on the appearance of the people that walked through their doors. When people came in “dripping” with expensive jewelry, or “talking on their cell phone,” driving cars that were more expensive than the ones driven by healthcare workers, or wearing more expensive clothes than some workers thought they should wear it became “personal” for workers. Some workers didn’t feel like it was fair that they, who were providing and even paying for these services, should have less than those they were providing for.

Healthcare providers saw themselves as disciplinarians, problem-solvers, advocates, and benefactors. As disciplinarians they spent much of their time teaching,

setting boundaries, and disciplining Medicaid patients to motivate them to change their behaviors. As problem-solvers they demonstrated initiative and creativity to overcome obstacles facing patients and office personnel. As advocates, they supported the rights of non-Medicaid and Medicaid patients and at times even supported the Medicaid program itself. Lastly, as benefactors, healthcare providers believed they were personally responsible for the services Medicaid patients were receiving and enacted that perception willingly or grudgingly.

In this chapter I have shown how Texas Medicaid provider personnel made sense of the constraints they faced from Medicaid within their daily work environment. I have discussed how their sensemaking strategies impacted their ability to function as professionals in both positive and negative ways. Lastly, I have shown how healthcare workers made sense of themselves as professionals and how they viewed their work. In the next chapter, I will discuss the implications that come from the findings of this study.

CHAPTER IV

SUMMARY AND IMPLICATIONS

In the wake of economic recession, more and more people are turning to Medicaid for help in accessing healthcare. A recent *USA Today* article reports that the current unemployment rate has pushed Medicaid enrollment across the country to “an all-time high...[and] accounts for nearly 22% of state spending when federal matching dollars are included, according to the National Association of State Budget Officers” (Appleby, 2011). Recognizing the expansion of Medicaid even in conservative states like Texas (Vestal, 2011) reinforces the urgency to better understand how Texas healthcare workers cope with the challenges they face as Medicaid providers.

The challenges Texas Medicaid providers coped with created a complex work environment where they were constrained by Medicaid policies/protocols and their own individual/professional values towards indigent care. Healthcare workers felt they were on their own in learning Medicaid policies and protocols as providers. Almost unanimously they agreed that Medicaid support staff were “flippant,” “rude,” unhelpful, unavailable, and untrustworthy. However, healthcare workers did acknowledge that Medicaid reimbursements came faster and typically involved fewer hassles than other insurance companies. Working with Medicaid also opened immediate access to a large patient population – a critical source of revenue for self-employed professionals, non-profits, and new businesses. All the healthcare workers I talked with closely identified with the practice of providing indigent healthcare, however they did clash with Medicaid in how that service was provided. They were aware that Medicaid carried a negative

public image that could harm their organizations and were upset with Medicaid's eligibility rules.

These healthcare professionals were also constrained by their own organizational rules and policies and by the Medicaid patients themselves. Private practices used business rules and policies as a way of protecting themselves from inevitable loss (a 'loss-driven' approach), public non-profit organizations largely used their rules and policies to funnel more patients toward Medicaid for higher revenues (a 'profit-driven' approach), while each healthcare service type faced their own unique challenges (dental, optometry/optics/ophthalmology, mental health, pediatrics). Workers also found it difficult to cope with Medicaid patients who didn't follow through on treatment plans, routinely missed scheduled appointments, allowed their children to run loose in their offices, and crowded their waiting areas with unscheduled family members.

Healthcare workers coped with these constraints by actively enacting practices of self-reliance and by discursive techniques focused on minimizing, blaming, and detaching. They enacted self-reliance through their own individual efforts, by networking with other Medicaid providers to reduce their workload, get advice, and leverage attention from Medicaid administrators, and by relying on in-house Medicaid experts. To cope with these challenges they also discursively minimized the problems they experienced, while maximizing their own values, blamed parents and Medicaid for patient problems, and detached the patient from the problem (at least in word).

In answering the final research question, I found that healthcare workers viewed themselves as disciplinarians, problem-solvers, advocates, and benefactors. As

disciplinarians, healthcare workers saw themselves as teachers and even parents whose job it was to create and enforce boundaries and to discipline negative behavior. As problem-solvers, they took responsibility to find solutions to the problems they experienced with Medicaid, and engaged in numerous problem-solving capacities with Medicaid patients. As advocates, healthcare workers believed non-Medicaid patients had a right to a decent office environment, Medicaid patients had a right to equal healthcare services, and the Medicaid program had the right to a good reputation.

How these professionals coped with these challenges created both positive and negative consequences for them. The meanings generated from their combined efforts to make sense shaped how they saw themselves and the work they were doing. In this chapter I will return to the theory guiding this study and discuss several theoretical and practical implications that can be drawn from the findings I have just reviewed.

Theoretical Implications

Identity Regions and “the Emotional ‘side’ of Identification”

This study supports and further develops Scott, Corman, and Cheney’s (1998) concept of identity ‘regions’ as part of their structurational model of organizational identification. In their model, Scott, et al. use the concept of identity regions to account “for the ability of members to draw on the same identity during the expression of identification or disidentification with any one target.” They point to the “front regions of the corresponding identity” as the conceptual locale of more positive expressions of identification, while “it is from these back regions of the identity that disidentifications, or negative identifications, are drawn” (pp. 315-316). The current study not only

represents a response to Scott, et al.'s recognition that "much remains to be done in clarifying these views" but also a response to "explore the emotional 'side' of organizational identification more fully than does the present articulation of this model" (p. 328).

Scott, et al.'s (1998) conceptualization of identity regions argues that workers move from positive to negative perceptions of organizational values and practices and vice versa. Such a movement represents a shift between the front and back regions of a particular identity construct. They argue that accessing the front and back regions of a particular identity construct is not unnatural and that even negative identifications (disidentifications) may serve to reinforce a salient organizational identity. They give the following example to demonstrate how even negative identifications can reinforce a salient construct of organizational identity:

[D]uring an especially turbulent time period in one's company, the organizational identity may remain very salient because of all the changes and discussions of them [roles, identities]; however, that saliency may serve to highlight disidentification with the organization if the employee resents the changes or the company's attitudes toward workers.

Identification and disidentification, then, represent the expression or enactment of a worker's agreement or disagreement (positive or negative valence) toward the organizationally derived values, attitudes, or beliefs used to structure their organizational identity. This worker sees themselves in light of the organization's values and practices, but draws on the back region of organizational identity in expressing those rules and

resources. While Scott, et al. (1998) define and characterize the regions of a particular identity, they do not postulate on workers who cope with co-existing positive and negative identifications within a single construct of identity or how they negotiate the inherent competition between these opposing valences in practice. Even in the example they provide it makes sense that this worker may still identify in a positive way with the overall mission of the organization and the work it accomplishes while expressing a negative identification with the company's posture toward workers or the changes they are seeing. Theoretically, such a situation could create within this worker the feeling of being torn between two competing emotions connected to this company (identification/disidentification), creating a tension in how they see themselves as a construct of that connection (organizational identity).

This study provides an opportunity to further develop the concept of identity regions by suggesting that organizational members experience competition between the front and back regions of a single identity construct. Organizational members experience and must negotiate the competing demands of coexisting *valences* of identification/disidentification. The results of this study indicate that healthcare workers clearly identified with some aspects of the Medicaid program and the patients on that program, while openly disidentifying with other aspects.

Those I interviewed highlighted Medicaid's poor support network as unreliable, unavailable, unhelpful, disinterested, flippant, and even rude. They described Medicaid patients as ungrateful, out of control, disrespectful and demanding. Such negative expressions are at the heart of the "back regions [which] allow for more 'regressive'

behavior in situations of copresence” (Scott, et al., 1998). It was obvious when healthcare workers were expressing their disidentification with the Medicaid program.

Those same workers, however, also expressed open identification towards the Medicaid program and the patients on that program. For example, Dr. Allan talked about how difficult it was to get in contact with Medicaid support representatives, criticized the support staff, talked about having to “write it [a bill for services] off” or “throw [a bill for services] in the trash” yet still said at the end of his interview that Medicaid was “a good system. I think everybody should do it.” Similarly, one respondent talked about being caught in a “mess of a maze” and getting no help in navigating that quagmire of policies, rules, and coding schemes when she first started working with Medicaid. Yet she identified with Medicaid when she acknowledged that no other insurance company could compete with how fast Medicaid could get a payment into her bank account.

Trying to make sense of these seemingly contradictory expressions of front and back regions of organizational identity would be difficult without acknowledging the ongoing negotiation between co-existing identifications/disidentifications. Healthcare workers expressed strong identifications and disidentifications as Medicaid providers. It wasn’t as if they were in the middle somewhere between the extreme positions found in Scott, et al.’s (1998) concept of front and back regions. They felt solid frustration and even anger against the Medicaid program but also maintained a preference towards Medicaid and/or Medicaid patients. The reality was that healthcare workers never really settled on whether they hated or preferred Medicaid - they both hated *and* preferred the

Medicaid program. Their identifications and disidentifications didn't cancel one another out since both existed independent and co-existent with the other as a holistic part of the Medicaid provider experience. Similar to how Scott, et al. (1998) connect situational activity foci to how organizational members negotiate multiple identities, this study suggests that organizational members may negotiate the front and back regions of a salient identity construct using a similar reference to the activity foci of a given situation.

References to distinct work processes and their relevant activity foci are actively part of the expressed emotional valence these participants experienced. For example, when talking about how they couldn't get help from Medicaid, workers were distinctly describing their experience in learning how to bill Medicaid for services and learning how to negotiate Medicaid support. These experiences were obviously infused with negative emotions as is apparent in how healthcare workers talked about Medicaid support staff and their experiences. When talking about their negative experiences with patients, it is clear that situational activity foci are used to guide whether they will communicate a positive or negative valence of their organizational identity as Medicaid providers (i.e., crowding their office space with family members, parents walking in "talking on their bluetooth," bragging about their new Cadillac, Hummer, or BMW, patients behaving as if they are "entitled" to care, acting in a "demanding" way).

When respondents expressed positive identifications toward Medicaid it was framed in the context of very different work processes than when they were expressing emotional valences connected to disidentification. Charla, for example, could fully disidentify with her negative experience trying to learn how to navigate the Medicaid

program and submit claims. However, her positive identifications are connected to how Medicaid pays her within 10 days and how it allowed her to help the kind of teenagers that need the most help. Similarly, when Lisa talked about the kinds of Medicaid patients that evoked a positive identification she references a unique set of activity foci (i.e., the patient's expression of gratitude, complimenting the frames they have on display, this woman had taken in her sister's children after a car wreck, etc.) distinct from those she referenced when expressing feelings of disidentification with Medicaid patients.

While additional research is needed to further clarify the interaction between the front and back regions of a single identity construct, this study makes some progress in this area. Healthcare workers demonstrated that within a single identity construct (i.e., Medicaid provider) they continuously negotiated the ongoing competition between co-existing identifications and disidentifications with the Medicaid program by referencing situational activity foci. These activity foci acted as reference points for the positive and negative emotions they expressed during identification and disidentification. Future research could further explain how this process works by specifically targeting organizational members that make sense of their organizational identity through co-existing references to the front and back regions of a single identity construct.

Making Sense of and Depending on Workplace Constraints

This study demonstrates how organizational members make sense of, constitute, cope with, and depend upon challenging workplace constraints. Weick (1995) argues that we individually bias particular cues over others in an effort to understand and give

meaning to an ongoing flow of raw experience. Such individual biases “derive cues as to what the situation means from the self that feels most appropriate to deal with it, and much less from what is going on out there” (Weick, 1995, p. 24). This places the primary locus of control in the sensemaking process within sensemakers and how they view themselves. Through our identities we “simultaneously try to shape and react to the environment” (Weick, p. 23) and create “objects for sensing or the structures of structuration” (Weick, p. 36). At the heart of the social constraints workers face, then, are the selves by which they “derive cues” from their environment. Individual and professional identity guides what kind of sense that is made.

In this study, healthcare workers created meaningful “sense” from their experiences with Medicaid that not only reflected but justified how they saw themselves as professionals. For example, as problem-solvers they meaningfully constituted their interactions with Medicaid support staff as problematic constraints. They openly described their support from Medicaid personnel as “discouraging” and frustrating challenges that unnecessarily complicated their work. These experiences were problematic and making sense of their experiences in this way was not only a reflection of their professional identities (i.e., noticing situational cues from the raw flow of experience that indicate problems because they are *problem-solvers*), but also created the need for a problem-solver (problem-solvers are only needed where there are problems to solve). They made sense of their own experiences as constraints and depended on these constituted meanings to justify how they saw themselves.

How organizational members shaped the meaning of the constraints they experienced had an impact on how they approached coping with these constraints. For example, when faced with challenging knowledge gaps on how to bill Medicaid, healthcare workers looked for solutions to their problems rather than simply giving up (e.g. they enacted self-reliance). Through self-reliance they attempted to resolve the problems they noticed with the Medicaid support they were receiving by researching answers for themselves, networking with other providers, and by relying on in-house experts. Seeing themselves as problem-solvers may account for why so many healthcare workers held to relying on themselves individually even when it resulted in relatively high costs in time, energy, and financial resources. Being a “problem-solver” would, at times, create additional problems for workers to solve. This dynamic underscores the unexpected consequences that can stem from how organizational members choose to enact meanings with which they highly identify.

While organizational members shaped the meaning of the constraints they experienced, their professional identities were also intimately tied to those constraints. Framing the constraint as a problem that needed to be resolved reinforced the need for a problem-solver. Interestingly, being a disciplinarian, advocate, and benefactor are all ways of being a problem-solver. Each of these identities enacts problem-solving in a slightly different way and in this way each of the professional identities healthcare workers latched onto reinforced the central theme of problem solving.

The constraints healthcare workers experienced crafted a unique opportunity for them to make sense of themselves as professionals in a preferred way. This suggests a

dependent relationship between constraints and how workers make sense of themselves and the work they do. Weick's (1995) conceptualization of sensemaking suggests that workers not only experience constraints, they have a vested interest in perpetuating the meanings of those constraints in order to perpetuate the meaning of their work. Such meanings allow them to make sense of themselves and their work in productive ways. There may be more to how constraints function as a catalyst for organizational sensemaking and professional identity than appears on the surface.

These findings reframe how we think about constraints. While constraints are typically thought of as inherently negative, this study suggests that there are equivocal meanings that can be associated with the experiences that constitute constraints. Constraints, workplace tensions, and paradoxes may serve an important function in organizational life. Even challenging constraints may make it possible to make sense of workplace identities that would otherwise remain unrealized. A salesperson, for example, would only view themselves as tenacious and persistent if faced with constraints that evoked sense-making activities justifying such a perception. Similarly, a firefighter may feel they are overwhelmed with paperwork and make sense of this experience as a workplace constraint they must manage, but by virtue of that constraint they perpetuate their preferred professional identity of being a high-performance, action-oriented worker. While constraints are difficult, binding, and challenging to deal with, they provide a robust counterweight by which organizational members can make sense of (and maintain sense of) valued identities.

Practical Implications

Low reimbursement rates have taken center stage as the primary explanation for why doctors and other healthcare providers are not willing to work with Medicaid (Appleby, 2011; Engel, 2006; Hicks, 2011; Ramshaw, 2011, Vestal, 2011). In fact, current conditions within the state of Texas are drawing even more focus on what Medicaid is paying doctors for their services. With a current bill proposed in the state legislature to slash what the state is willing to pay for Medicaid payments by 10 percent, John Holcome, chairman of the Medicaid committee at the Texas Medical Association believes “we’ll see a reduction again in the number of physicians that are willing to see Medicaid patients” (Hicks, 2011).

Cuts to state expenditures for Medicaid are not only happening in Texas, but across the country. An article in *USA Today* reports that “most states have cut services and budgets during the recession.” With federal stimulus packages running out on June 30 of 2011, it makes sense that state Medicaid dollars may continue along this downward trend.

Ironically, while Medicaid spending is being reduced in order to help bring state budgets under control, there is still a significant drive to expand Medicaid services to more people. Fueled by federal law, 16 million more people are expected to be covered by Medicaid in the U.S. by the year 2014 (Vestal, 2011) and *USA Today* reports that the number of people trying to get on Medicaid across the country is at “an all-time high” due to current unemployment trends. The state of Texas, along with 11 other states, has recently expanded the size of its Medicaid managed care program “for low income

children, pregnant women, the disabled & frail elders” (Vestal). Such moves, combined with the looming federal mandate expanding Medicaid, have created a situation where states are cutting Medicaid expenditures while continuously expanding care. Finding alternative means by which to motivate doctors to either continue as or become Medicaid providers is becoming an increasingly important issue.

Without ignoring the significant impact that Medicaid reimbursement rates have on healthcare providers and their willingness to work with the state Medicaid program, this study suggests there are other significant factors that influence whether healthcare providers are willing to work with Medicaid. Those interviewed in this study spent the majority of their time talking about at least three non-monetary factors that made it difficult for them to work with Medicaid. First, healthcare workers didn’t believe they were getting enough support as Medicaid providers from official Medicaid channels. It became almost cliché during my interviews to hear healthcare workers talk about how confusing their first few years were working with Medicaid. Dr. Allan recognized there are “dentists that are just doing it for free...[and] they could get paid for it, if you properly show them how to do it, and not make it so complicated.” Kathy’s comment that she felt bad for anyone who had just started trying to learn how to work with Medicaid is sobering – especially if states want to have enough providers to continue meeting the needs of their indigent populations.

Second, healthcare workers consistently talked about the social problems that came from working with Medicaid. Diane mentioned that other offices refused to work with Medicaid because of the bad reputation Medicaid patients had in the area. Dr.

David said other dentists discouraged him from working with Medicaid patients when he first started looking into becoming a provider and told him horror stories about kids “peeing in the front room” and being totally out of control. Dr. Rasmussen admitted that being a Medicaid provider carried “risks” because it could scare off higher-paying patients. Healthcare workers were frustrated across the board with Medicaid patients because they had a reputation of being out of control, missing appointments, not following through on treatment, and crowding their office space. With so many private practices facing a potential 10% cut in reimbursements, it makes sense for Medicaid administrators to institute policies that will reduce some of these social factors that discourage healthcare providers from working with Medicaid. Given the significant negative impact of patient misbehavior, it might be necessary to impose sanctions on patients and/or parents whose children demonstrate repeated and generally recognized unacceptable behavior in an office (i.e., peeing in the front room, jumping all over furniture, etc.) Focusing sanctions on educating parents through the use of community classes teaching appropriate public behavior and/or how to more effectively discipline (e.g. control) their children rather than simply kicking them off the system altogether seems like a better alternative for families whose children need the healthcare services, but haven’t internalized appropriate conduct. If handled in a constructive way, with an eye toward curbing negative behavior rather than eliminating people from the program, such efforts could not only benefit parents, but garner additional support from healthcare providers who strongly identify with helping indigent families get healthcare and see themselves as disciplinarians interested in teaching and enforcing boundaries.

Lastly, healthcare workers acknowledged the speed and reliability of getting paid by Medicaid as a significant factor that kept them working with Medicaid as providers. Some of what Medicaid was doing was openly regarded as ahead of the curve for the healthcare workers I interviewed. Workers appreciated the ease of getting paid electronically and commented on how a 10-day turnaround was not only helpful, but significantly better than other insurance companies. Having a fast turnaround time for submitted claims was especially important to small business owners like Charla and Amanda and relatively new healthcare providers like Dr. David who depended on quick payments in order to keep their businesses running. In addition, healthcare workers talked about Medicaid reimbursements as being much more reliable than what they got from other insurance companies. While the pay amount might be going down, these positive aspects of working with Medicaid may entice other small business owners to become Medicaid providers.

Ultimately, the combination of decreasing Medicaid reimbursement dollars and steep mandates to expand coverage leads to significant motivation for state lawmakers to address some of these non-monetary issues. Furthermore, the state has additional motivation to address these non-monetary issues because they seem to be affecting the number of doctors willing to work with Medicaid. Following a legal dispute filed against the state of Texas for not providing enough accessible healthcare for children enrolled in Medicaid, the state was compelled to increase their Medicaid expenditures by 1.8 billion dollars in 2007 (Hicks, 2011). As part of this settlement the state agreed to “maintain standards of accessibility of healthcare services for citizens on Medicaid”

(Hicks). According to some hospital and child advocacy groups, losing too many Medicaid doctors “would increase the likelihood that the state violates the accessibility standards it agreed to, potentially setting the stage for another legal battle” (Hicks). Focusing on non-monetary fixes to Medicaid may go a long way to retain providers who are already in the system and recruit healthcare providers who want to help indigent groups, avoiding costly legal consequences currently facing the state.

Medicaid Provider Survival Strategies

This study also describes several sensemaking techniques healthcare workers used that helped them manage working with Medicaid as providers. These techniques represent a collection of “best practices” for Medicaid providers and highlight the different kinds of challenges they faced in their work. The data uncovered at least two substantive ways healthcare workers coped with the challenges they faced with Medicaid: 1) enacting self-reliance via individual effort, networking with other providers, and relying on in-house experts, and 2) discursively framing ongoing tensions via minimizing, blaming, and detaching.

These techniques had tangible benefits and drawbacks. For example, workers who coped with Medicaid deficiencies by relying on their own individual efforts did so with the hope of avoiding costly billing errors. For example, when Dr. Martinez found that her “billing person” was making mistakes on how they billed Medicaid, she took over the responsibility for billing Medicaid herself. Her object in doing this was to reduce the number of billing mistakes and increase her overall profit margins. When faced with the necessity of learning how to bill Medicaid accurately, she quickly realized

she couldn't trust the Medicaid support staff and was compelled to work late into the night to find the answers to her questions on her own. Similarly, when Kathy was concerned about unreliable information from Medicaid phone support personnel, she made it a point to call at least three separate times to ensure she each worker she talked with gave her the same answer. By doing this she was able to detect when she was getting erroneous direction from Medicaid support personnel. However, once again, she had to invest considerable time to do this. Most workers were frustrated they had to find answers on their own because they simply didn't have expendable time or energy to waste. Furthermore, these data suggest that those who rely on their individual effort must learn by "trial and error" before they get things right. Wendy mentioned that when she first started working for Dr. Allan, this meant the mistakes she made on billing codes couldn't be recovered. Dr. Martinez said she had friends who had made billing mistakes that resulted in thousands of dollars of unrecovered service fees. While relying on individual effort was definitely better than relying on Medicaid support personnel, the learning curve costs valuable time, energy, and money.

Similarly, organizations that rely on in-house experts avoid having to educate all their workers on how to use Medicaid. Workers, especially in large organizations, could focus on doing their job and didn't have to worry as much about dealing with Medicaid. Most of the healthcare workers who had an appointed in-house expert admitted they didn't know much about Medicaid, but they all knew exactly where to go when they had a question. Using an in-house expert was a significant time saver for larger organizations.

Finally, when healthcare workers couldn't get the answers they needed through formal channels, some relied on other Medicaid providers for the answers they needed. These data suggest that this is a powerful way workers can reduce their workload and leverage attention from Medicaid administrators on issues they share in common with other providers. Working with one another, healthcare workers significantly reduced the workload and time commitment involved in finding answers alone and benefited from the increased knowledge base and experience available to them by connecting with other professionals. This study demonstrates that healthcare providers can benefit from networking with other Medicaid providers who compete with them for business. Wendy mentioned that talking with other front desk workers was not only critical to understanding how to bill Medicaid correctly, but that those workers were typically happy to help. Relying on one another represented the most common, productive and efficient enactment of self-reliance among healthcare workers found in this study.

This study also highlights how some problems can be dealt with and others must be lived with and therefore require a different set of coping techniques. While enacting self-reliance worked to tangibly empower healthcare workers with knowledge so they could remove obstacles preventing them from accurately submitting claims, sometimes the challenge was not about removing the problem as much as it was in learning how to live with a problem that didn't have an immediate solution. For example, healthcare workers in this study were compelled to live with the knowledge that many times those that need healthcare services do not qualify for Medicaid services while those who seem fully capable of funding their own healthcare do qualify. Unable to change this problem,

healthcare workers still had to provide professional service. Workers recognized that even though they disagreed personally they still provide “professional” service to their patients. This is especially important since most of those on Medicaid are kids and need the help these workers can deliver.

Minimizing the problem seemed to be an effective way of coping with the healthcare workers faced. It allowed them to admit that a problem existed, but reduced the relative scope of the problem. This reminded workers that the problems they faced were challenging, but should be viewed within the full context of patients who came in for their services. Using this technique, healthcare workers could live with patient challenges by reducing the relative impact of those challenges. Minimizing the problem helped them feel validated in their frustrations while still giving them good reasons to stay on as a Medicaid provider.

Minimizing the problem by maximizing their identification with indigent healthcare, on the other hand, may actually make it easier to break away from Medicaid. Dr. Allan hinted at this when he talked about the dentists who were still looking for ways to assist the poor in getting their teeth cared for, but refused to work with Medicaid to accomplish those efforts. These doctors had a strong identification with indigent healthcare, but largely disidentified with Medicaid as the vehicle of that care. Similarly, Julie, who highlighted their “Christian” values as their core reason for working with Medicaid, viewed Medicaid as just another “insurance” company. She said if they could make enough money without working with Medicaid, they would leave the program. Feeling little attachment to Medicaid as part of identifying with indigent healthcare may

convince healthcare providers who experience significant frustrations with Medicaid to simply find a more convenient vehicle by which to engage in helping the poor.

This study also suggests that blaming parents and/or Medicaid for problems healthcare workers encounter with Medicaid patients in general allows workers to feel they are providing equal and “professional” service to each patient regardless of how they are paying for services. Detaching the patient from the problem seemed to be an effective way to make sense of obvious abuses to the Medicaid program while still providing “professional” patient treatment. However, some healthcare workers demonstrated that it may be easier to detach in word than in deed.

This study contributes several valuable theoretical and practical implications. Theoretically, it reinforces and further refines Scott, Corman, and Cheney’s (1998) structurational model of organizational identification. It also reframes how we look workplace constraints as meaningful products of how workers make sense of themselves professionally. From a practical perspective, this study suggests that while low reimbursement rates contribute to whether healthcare providers will work with Medicaid, there are significant social challenges from working with Medicaid that may pose an equal or greater risk of deterring them. This study also offers several best practices for healthcare workers interested in more effectively coping with the constraints they experience as Medicaid providers.

Limitations and Directions for Future Research

Not every professional I tried to recruit for this study was able to participate. While this may place some limitations on these findings it also suggests rich directions

for future research. After contacting numerous private pediatric clinics, I was not able to secure participation from any of them. Of the three that responded to multiple phone messages, one practice manager was candid enough to tell me they were far too busy to participate. Another that demonstrated interest initially would not return phone calls when I called to set up an interview time. While pediatric workers in the public non-profit sector definitely face challenges coping with overflows of information and patients that had bearing on this study, it would have been helpful to see how the private sector is coping with the host of current healthcare challenges directly effecting their businesses (Appleby, 2011; Biles, 2007; Hicks, 2011; Fikac, 2010; Freking, 2006; Garrett, 2010; NBCDFW.com, 2010; Ramshaw, 2011; Salt Lake City Tribune, 2007; Vestal, 2011). Future research should target this group and see how their perceptions of working with Medicaid compare with the public sector and other healthcare service types covered in this study.

It would also be productive to secure additional interviews with former Medicaid providers. While I attempted to do this, not only was it difficult locating former Medicaid providers, but it was difficult getting them to talk with me once I did. Most expressed severe frustration with Medicaid over the phone but dodged my efforts to secure interviews. However, this group would prove invaluable in better understanding why some leave and others continue on as providers in spite of the challenges. It would also be interesting to better understand how they made sense of themselves as Medicaid providers and how those perceptions might have influenced how they experienced the constraints they felt from the Medicaid program.

While it wasn't the focus of this study, these data suggest that future research with Medicaid support personnel and Medicaid patients could yield important findings. Medicaid support personnel likely face their own challenging constraints in the work they do. How they manage their constraints may explain why they interact with healthcare providers in the ways they do. Seeing the Medicaid experience from their perspective could further uncover the pressures that influence their practices and how they make sense of themselves professionally. Future research could profit from additional studies that highlight training (or lack thereof) and workload constraints in particular.

Future research could also benefit from a closer look at Medicaid patients that homes in on how they make sense of themselves and the challenging constraints they face. With children on Texas Medicaid, it was especially interesting for me to hear how Medicaid providers made sense of their work with Medicaid patients. In particular it stood out to me that workers were frustrated with Medicaid patients who brought all their children with them when only one child had a scheduled appointment. This stood out to me because I knew, from personal experience attending Medicaid meetings, that many of the parents who attended were single mothers and had little or no way of leaving their other children at home during an appointment. Similarly, my experience with children of Medicaid also sensitized me to how vulnerable parents feel when they have to admit they are on Medicaid. It may be that patients who dress in name brand clothes do this as a way of coping and defending themselves from these feelings of vulnerability and inequality that accompany the "Medicaid" label. It would be helpful to

better understand how Medicaid patients and their parents/guardians make sense of themselves and their interactions with Medicaid providers. Likely, such additional findings may highlight the complexities and challenges they face by being labeled with the “Medicaid” program and the communicative practices that support and contend with such structures.

In addition, while the implications of these data suggest a deeper understanding of Scott, Cormon, and Cheney’s (1998) concept of identity regions, these are only initial findings that deserve additional scholarly attention. In particular, this study suggests there is much to be gained by investigating how emotion factors into discussions over identification and disidentification. It also suggests we have much to learn not only from discussions about multiple identities and multiple targets of identification, but also from additional research targeting how organizational members simultaneously express affiliation with and contention toward a single target. This study suggests a starting point, but additional research is needed to further explicate the relationship between the front and back regions of Scott, et. al.’s model and how emotion is both the process and the product of such interactions.

Lastly, this study also suggests that organizational constraints play a much more crucial role in how organizational members make sense of themselves than previously understood. Not only do workers shape the constraints they face, but those constraints are necessary points of resistance needed for them to fully express and make sense of their own identities. Once, again, this study begins a conversation that needs additional

scholarly voices to further unpack the relationship between constraints and professional identities.

Conclusion

Healthcare workers face a challenging and complex work environment as Medicaid providers. They are constrained by Medicaid policies and protocols, by their individual and professional values toward indigent care, by their own organization's rules and policies, and by Medicaid patients themselves. This study provides two theoretical implications that home in on how these workers coped with these constraints and how they made sense of themselves as professionals. Theoretically, this study refines and expands Scott, Corman, and Cheney's (1998) concept of identity regions as part of their structural model of organizational identification. These data suggests that organizational members not only negotiate between multiple targets of identification and constructs of identity by relying on situational activity foci, but they also experience co-existing identifications and disidentifications towards a single target. Similar to how organizational members negotiate multiple identifications, this study suggests members negotiate ongoing identifications and disidentifications by referencing salient situational activity foci which make it possible for them to simultaneously identify with some aspects of the target with which they identify while disidentifying with others. We also gain a better understanding of the potential role that constraints play in how organizational members are able to make sense of themselves and the work they do. Additional research is needed to further understand these relationships.

This study also suggests that while the financial constraints facing Medicaid providers play a definite role in why so many healthcare providers refuse to work with Medicaid, there are also significant non-monetary reasons that deserve equal attention. During a time when states are reeling from budget problems and federal mandates to expand healthcare, improving social factors such as patient behavior is a cost-effective way to recruit and keep Medicaid providers. In addition, this study suggests that current providers experience fewer additional constraints when they rely on other providers when experiencing Medicaid problems and when they rely on in-house Medicaid experts.

This study began by considering the challenges facing healthcare workers in their complex work environment. However, healthcare workers demonstrate that they not only shape the constraints they face, but that they have found ways of productively coping with these constraints in the work they do. While the healthcare dilemma continues to expand over the country and throughout each individual state (particularly in Texas), these workers demonstrate that even more important than the constraints they face are how they choose to engage those mistakes. They may be in the 'middle', but these workers demonstrate that being in the 'middle' can be managed.

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APPENDIX A

Interview Guide

Now you've had a chance to look over the consent form and to sign it – do you have any questions that I can answer for you? Ok, let me tell you a little about what I'm doing with this project.

I want to understand what it's like working within the Medicaid system from the provider's perspective. Let me start by getting a little information about you and about where you work.

1. Ok, _____ (NAME OF PERSON) tell me a little about yourself...
 - a. What is your job title here? What kind of work do you do?
 - b. How long have you worked here?
 - c. How long have you worked as a _____?
2. Tell me a little about _____ (NAME OF PRACTICE).
 - a. How long has it been around?
 - b. How many people started out working here?
 - c. How many people work here now?
 - d. How many patients do you service?
 - e. What kinds of services does this office provide?
3. How long has _____ (NAME OF PRACTICE) been working with Medicaid?
 - a. What's your relationship like with Medicaid? Has it always been this way?
 - b. What proportion of your patients use Medicaid to pay for services?
4. What's it like to work with Medicaid here?
 - a. What's the hardest part(s) about working with Medicaid?
 - b. What's the best part of working with Medicaid?
 - c. What experiences have you had that make you feel this way?
 - i. What happened in this/these experiences?
 - ii. When did this happen?
 - iii. Who was involved? What did you do? Why did you do that?
 - iv. Was this/Were these experience(s) typical or out of the norm?
5. What are some of the rules you have to follow to work with Medicaid?
 - a. How do you feel about these rules?
 - b. If you could change anything about the Medicaid rules what would you change? Why would you make this change?

6. How do you feel about providing healthcare to those on Medicaid personally?
Professionally?
 - a. Is there an experience you can think of that shows how you feel about Medicaid?
 - b. Are there times when the Medicaid rules and policies conflict with your own values? Professional standards?
 - i. How often does this happen? How do you handle this? How have you seen others handle this?
 - ii. How do you explain the choice you made to others?
7. Have there ever been times when you've had to adjust the way you run the office/do business to make things work out with Medicaid? Tell me a time when this has happened.
 - a. How often does this happen?
 - b. What goes into making this kind of change?
8. What kinds of business policies do you have that make it either easier or more difficult to work with Medicaid?
 - a. Do you think people that work in other healthcare services face similar pressures?
 - b. Why?/Why not?
9. What's it like to work with Medicaid patients themselves?
 - a. Can you share a typical experience of dealing with a Medicaid patient?
 - b. What makes this experience typical to you?
10. What's it like when you talk/interact with Medicaid personnel?
 - a. Do you have any experiences that come to mind? What happened?
 - b. Is this a typical experience with Medicaid workers or is it unusual?
11. Would your work be different if you only serviced people with private insurance?
 - a. How so?
 - b. Would this be easier or harder to manage in your opinion? Why?
12. Have you thought about NOT servicing Medicaid patients?
 - a. If so, what's kept you from making this decision?
 - b. Have you known any businesses that decided not to service Medicaid patients? How did that turn out for them?
13. If you could talk to Medicaid patients and give them any kind of advice that might make it better for health care providers, what would you say?
14. If you could talk to Medicaid bureaucrats/personnel about how life could be made better for those "in the middle" providing health care services, what would you say?

APPENDIX B

Initial Cold Calls

: Hello, I was wondering if you take Medicaid?

[If they answer no, then I will thank them and close the phone call. If they answer yes, I will move on to the other questions in the script below.]

: My name is Cade Spaulding and I'm doing some preliminary work for a research project I am planning on doing for my dissertation at Texas A&M and wondered if you could tell me how many people work there?

: How many of those people are doctors/dentists/optometrists, etc.?

: How many of those people are nurses/assistants/technicians, etc.?

: How many of those people are frontline staff/secretaries/etc.?

: Do you have a rough idea of how many patients you serve?

[I will thank them and close the call.]

APPENDIX C

Initial Recruitment Calls

: Hello, I've been told that your practice accepts Medicaid.

: Good. Well, I'm working on a research project that targets what it's like to work within the Medicaid system from the provider's perspective. I'm looking for Medicaid providers in the area that might be interested in participating. Who could I talk to there that might be able to make a decision about this?

: Great – thanks!

[If they ask me to call back at a different time to catch the person in charge, I'll schedule a recall time. If the person is available I'll move to the script below]

: Hello, I just got done talking to _____ (NAME OF PERSON) and they said you might be the person I should talk to. My name is Cade Spaulding and I'm working on a research project for my dissertation at Texas A&M that targets what it's like to work within the Medicaid system from the provider's perspective. I'll be doing 30-45 minute interviews with personnel at all different levels asking them questions about their experiences and plan to hold the interviews outside of the normal working hours wherever they feel most comfortable. I'm looking for Medicaid providers in the area that might be interested in participating in this study. Is there a time that I can bring by some printed material about my research and talk a little more about this with you and your staff?

: Great- thanks! I'll plan on seeing you _____ (SCHEDULED TIME).

APPENDIX D

Consent Form

In the Middle: Experiencing Medicaid as a Texas Health Care Provider

Introduction

The purpose of this form is to provide you information that may affect your decision as to whether or not to participate in this research study. If you decide to participate in this study, this form will also be used to record your consent.

You have been asked to participate in a research project studying what it is like to work within the Medicaid system from the provider's perspective. The purpose of this study is to better understand how health care workers make sense of their work environment and themselves as they interact with Medicaid policies, personnel, and patients. You were selected to be a possible participant because you work for a health care provider that accepts Medicaid.

What will I be asked to do?

If you agree to participate in this study, you will be asked to participate in an interview where you will be asked several questions about your work experiences particularly as they relate to Medicaid policies, personnel, and patients. This study will take about 45 minutes to one hour and may include a request for additional interviews.

Your participation will be audio recorded.

What are the risks involved in this study?

The risks associated with this study are minimal, and are not greater than risks ordinarily encountered in daily life.

What are the possible benefits of this study?

The possible benefits of participation include an opportunity to make suggestions on ways to improve the relationship between health care providers and Medicaid personnel/patients/policies. You will also receive a report when the study is completed that will detail the study's findings. Indirect potential benefits include the chance to share your own experiences and broaden the range of issues policy makers consider when dealing with Medicaid within the state of Texas. Participants will also potentially gain a better understanding of how work matters dealing with Medicaid impact their current work experience.

Do I have to participate?

No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University or your employer being affected.

Who will know about my participation in this research study?

This study is confidential. The records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published. Research records including transcribed texts and research notes will be stored securely and only myself and my dissertation advisor will have access to the records.

If you choose to participate in this study, you will be audio recorded. Any audio recordings will be stored securely and only myself and my dissertation advisor will have access to the recordings. Any recordings will be kept for 3 years and then erased.

Is there anything else I should consider?

Interviews will be held in a location and time of your choosing.

Whom do I contact with questions about the research?

If you have questions regarding this study, you may contact Cade Spaulding, 979-764-0805, cade.spaulding@tamu.edu or Katherine Miller, Ph.D., 979-862-6780, kimiller@tamu.edu.

Whom do I contact about my rights as a research participant?

This research study has been reviewed by the Human Subjects' Protection Program and/or the Institutional Review Board at Texas A&M University. For research-related problems or questions regarding your rights as a research participant, you can contact these offices at (979)458-4067 or irb@tamu.edu.

Signature

Please be sure you have read the above information, asked questions and received answers to your satisfaction. You will be given a copy of the consent form for your records. By signing this document, you consent to participate in this study.

Signature of Participant: _____

Date: _____

Printed:

Name:

APPENDIX E

Email Request For Feedback on Research Findings

Hi (participant name),

In 2008-2009 you participated in a research study for my dissertation on what it is like to work with Medicaid as a Texas Healthcare Provider. As a participant in this study, I wanted to provide you with a preliminary copy of my findings from interviews conducted with other providers. I am interested in any feedback you can give me to make this study as accurate as possible when it goes to a final draft. Please feel free to contact me with any questions or comments at this email address.

Best regards,

Cade Spaulding
cspauldi@uwsp.edu

APPENDIX F

Participant Request for Review and Feedback

I made every effort to accurately represent your views in this study. However, I can't be sure I've come close to a full picture of what this experience is like without including everyone I interviewed in the writing process. Please take time to read these findings.

In this paper I have worked hard to express the themes that stood out to me from interviews of 36 professionals from areas of healthcare: dental, pediatrics, mental health, and optometry/optics. The transcribed interviews totaled over 350 pages of double-spaced text making this a challenging task. If you find something you agree with, I would be happy to hear from you. I would be equally happy to hear from you if you see something that doesn't sound right or if you think I have misrepresented your words or views in any way. Ultimately, this study should represent how you view the work you do with Medicaid and I want it to be as accurate as possible. Please send any feedback to cspauldi@uwsp.edu at your convenience. I will need feedback by March 1, 2011 to have time to review the feedback, contact you for possible clarification, and make any corrections to include in the finished report.

I have included a full copy of my findings to date. All names have been altered to protect privacy and ensure confidentiality. After I have finished the final chapter, I will provide each participant with an executive summary (digital and/or paper format). A full copy of this research study will be available in digital format with email request sent to cspauldi@uwsp.edu.

Not every participant will want to review the entire draft of my findings. However, I didn't think it would make everything completely transparent if I didn't show you exactly how I was using your words. I have included headings and summaries of each major finding to make it easier to read. Upon request I can supply individual participants with their aliases so they can more quickly locate their own interview quotes and how I used them.

APPENDIX G

Participant Demographics Table

Service Type	Org Type	Sex	Race	Position Type
Dental	Pub/Private	F	Hispanic	Clinical & Office Staff
Dental	Pub/Private	F	White Caucasian	Clinical Staff
Dental	Pub/Private	F	White Caucasian	Office Staff
Dental	Private	M	White Caucasian	Clinical Staff
Dental	Private	F	African American	Office Staff
Dental	Private	F	White Caucasian	Clinical Staff
Dentistry	Private	M	Asian American	Clinical Staff
Dentistry	Private	F	White Caucasian	Office Staff
Mental Health	Private	F	Hispanic	Clinical Staff
Mental Health	Pub/Private	M	White Caucasian	Office Staff
Mental Health	Pub/Private	F	White Caucasian	Clinical Staff
Mental Health	Pub/Private	F	White Caucasian	Clinical Staff
Mental Health	Pub/Private	F	White Caucasian	Clinical Staff
Mental Health	Pub/Private	F	African American	Office Staff
Mental Health	Pub/Private	F	White Caucasian	Office Staff
Mental Health	Private	F	White Caucasian	Clinical & Office Staff
Mental Health	Private	F	White Caucasian	Clinical & Office Staff
Mental Health	Pub/Private	F	African American	Office Staff
Mental Health	Pub/Private	F	Asian American	Clinical Staff
Mental Health	Pub/Private	M	African American	Clinical Staff
Mental Health	Pub/Private	M	White Caucasian	Clinical Staff
Mental Health	Pub/Private	F	African American	Clinical Staff
Mental Health	Pub/Private	F	African American	Clinical Staff
Ophthalmology	Private	M	White Caucasian	Clinical Staff
Ophthalmology	Private	F	White Caucasian	Office Staff
Ophthalmology	Private	F	Hispanic	Office Staff
Optics	Private	F	White Caucasian	Clinical Staff
Optics	Private	F	White Caucasian	Clinical Staff
Optics	Private	F	White Caucasian	Clinical Staff
Optometry	Private	F	White Caucasian	Office Staff
Optometry	Private	M	White Caucasian	Clinical Staff
Optometry	Private	F	White Caucasian	Office Staff
Pediatrics	Pub/Private	M	White Caucasian	Clinical & Office Staff
Pediatrics	Pub/Private	F	Hispanic	Office Staff
Pediatrics	Pub/Private	F	African American	Office Staff
Pediatrics	Pub/Private	F	African American	Office Staff

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